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No. 01-199

IN THE

Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC., AND
GREATER NEWPORT PHYSICIANS, INC.,
Petitioners,

v.

BARBARA MCCALL,
Individually and as Trustee, etc.,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of California

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether Medicare beneficiaries may file a state court lawsuit against a Medicare contractor based on an allegedly wrongful denial of Medicare benefits without first administratively exhausting their claims and seeking federal judicial review as required under subsections 405(g) and (h) of the Medicare Act, 42 U.S.C. § 405(g) and (h), merely by styling their attack as a state law tort claim seeking consequential damages rather than Medicare benefits.

PARTIES TO THE PROCEEDING

All of the parties are listed in the caption of the case. Dr. Lakshmi Shukla was, with the petitioners, a defendant in the case below in the Supreme Court of California. Pursuant to Rule 29.6 of the rules of this Court, PacifiCare of California, Inc., is wholly owned by PacifiCare Health Plan Administrators, Inc., which is wholly owned by petitioner PacifiCare Health Systems, Inc. PacifiCare Health Systems, Inc., is publicly held, and Capital Group International, Inc., is the only publicly held company that owns 10% or more of its stock. Greater Newport Physicians, Inc., has no parent corporations, and no publicly held company owns 10% or more of its stock.

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PETITION FOR A WRIT OF CERTIORARI

PacifiCare of California, Inc., PacifiCare Health Systems, Inc., (collectively, "PacifiCare"), and Greater Newport Physicians, Inc. ("GNP") (all collectively, "petitioners") respectfully petition for a writ of certiorari to review the judgment of the Supreme Court of California in this case.

OPINIONS BELOW

The opinion of the Supreme Court of California (App. 1a-39a) was entered on May 3, 2001, and is reported at 21 P.3d 1189. The opinion of the Court of Appeal of the State of California, Fourth Appellate District, (App. 40a-52a) was entered on August 17, 1999, and is published in part at 87 Cal. Rptr. 2d 784. The order of the Superior Court of California, County of Orange, sustaining PacifiCare's demurrer was entered on August 4, 1998 (App. 55a-59a); and an order and amended order granting judgment to GNP were entered on August 3, and August 4, 1998, respectively (App. 60a-65a). None is published.

JURISDICTION

The opinion and final judgment of the Supreme Court of California on its jurisdiction were entered on May 3, 2001. This Court has jurisdiction pursuant to 28 U.S.C. § 1257. See *Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 479-83 (1975).

STATUTORY PROVISIONS INVOLVED

This case involves 42 U.S.C. § 405(g) and (h) (App. 67a-70a), which have been applied to the Medicare Act by 42 U.S.C. §§ 1395ff(b), 1395ii, and 1395mm(c)(5)(B).

42 U.S.C. § 405(g) provides in pertinent part that:

> Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of

> such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business . . . .

42 U.S.C. § 405(h) provides that:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

STATEMENT OF THE CASE

1. In this case, the California Supreme Court held that a Medicare beneficiary who did not exhaust federal administrative remedies nevertheless may file state law claims against a Medicare contractor "arising out of its refusal to provide services under a Medicare-subsidized health plan." App. 1a. The court thus allowed a state court lawsuit based on the HMO's alleged failure to provide Medicare benefits and fulfill other duties under the Medicare Act to proceed, even though the Medicare beneficiary had not challenged the failures through the process administered by the Secretary of Health and Human Services ("the Secretary") and the Health Care Financing Administration ("HCFA").[1]

2. The facts alleged in the Amended Complaint are straightforward. Respondent George McCall was a Medicare beneficiary. Medicare is a two-part federal health insurance program for people 65 and older and for certain disabled

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[1] In June 2001, HCFA changed its name to the "Center for Medicare and Medicaid Services," but the petition refers to this entity as HCFA.

individuals. See 42 U.S.C. § 1395 *et seq.* A Medicare beneficiary may elect to receive health care on a fee-for-service basis in which the patient obtains medical care from a physician who submits a bill to a Medicare carrier. In the alternative, a Medicare beneficiary may enroll with an HMO that has a contract with HCFA to provide services to Medicare enrollees. *Id.* § 1395mm.[2] Respondent McCall elected to receive his Medicare benefits by enrolling in PacifiCare, an HMO. His primary care physician was Dr. Shukla and his physician provider group was GNP.

The Medicare Act covers, *inter alia*, the costs of hospitalization and related expenses that are "reasonable and necessary" for the diagnosis and treatment of illness or injury. See *id.* §§ 1395y(a)(1)(A), 1395k, 1395*o*. McCall, who suffered from progressive lung disease, sought approval from PacifiCare and GNP to receive a lung transplant. PacifiCare and GNP, however, allegedly determined that the requested lung transplant was not a reasonable and necessary treatment for McCall's condition. See App. 2a ("[a]llegedly, Dr. Shukla, PacifiCare and GNP repeatedly refused to refer Mr. McCall to a specialist for a lung transplant or provide other needed care, and ultimately forced him to disenroll from PacifiCare in order to get on the Medicare list for a transplant").[3]

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[2] Medicare HMOs may cover additional benefits (such as dental, vision, or pharmaceutical) beyond those covered by fee-for-service Medicare, but they always provide at least those covered by the latter.

[3] More specifically, McCall's allegation is that he "wanted to go to the best facility [for a lung transplant]" which he believed to be the University of California at San Diego ("UCSD"), and that PacifiCare "refused to pay for the best facility," instead covering lung transplants at the UCLA and Cedar-Sinai hospitals. *See* McCall Dep. at 280-81 (July 7, 1988) (lodged with the Court). *See id.* at 281 (stating that he was "not now saying that [PacifiCare] refused to pay for a lung transplant . . . just saying that [PacifiCare] refused to pay for a lung transplant . . . at UCSD").

Under the Medicare Act, as Medicare providers, PacifiCare and GNP are required to "provide meaningful procedures for hearing and resolving grievances between the organization . . . and members enrolled with the organization." 42 U.S.C. § 1395mm(c)(5)(A). And, a "member enrolled with an eligible organization under this section *who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled* and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary." *Id.* § 1395mm(c)(5)(B) (emphasis supplied). The regulations implementing this section of the Act provide Medicare HMO enrollees with an appeal and review process that is virtually identical to that provided to Medicare fee-for-service enrollees – an HMO determination regarding coverage and payment (42 C.F.R. § 417.606), an internal review process upon request for reconsideration (*id.* § 417.616), mandatory submission of adverse determinations to HCFA (*id.* § 417.620), hearing before an Administrative Law Judge upon request (*id.* § 417.632), an appeal to the Departmental Appeals Board (*id.* § 417.634), and, federal district court review (*id.* § 417.636). Critically here, the regulations also provide for expedited review of certain HMO determinations where the time frame of the routine process "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." *Id.* § 417.609(b).

McCall, however, did not follow the procedures of the Medicare Act in challenging the HMO's alleged refusal to provide him with a lung transplant. Instead, he disenrolled from PacifiCare and resumed coverage with a fee-for-service Medicare physician.[4] He and his wife also filed a state court action against PacifiCare, GNP and Dr. Shukla.

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[4] While this case was on appeal, McCall's fee-for-service Medicare physician conducted tests and determined that the transplant was reasonable and necessary, and McCall received the transplant at UCSD. He died shortly thereafter. App. 2a n.1.

The McCalls' operative amended complaint alleged eight state law causes of action for damages based on violations of state law and federal regulatory duties (including duties set forth in regulations implementing the Medicare Act) and a ninth for injunctive relief from unfair business practices. App. 76a-93a. Each of the claims rested on the petitioners' alleged violations of duties under the Medicare Act. See Amended Complaint, *id.* Count 1 sought damages for negligence. Five of the duties alleged to have been violated in Count 1 are expressly *alleged* to arise from Medicare regulations. *Id.* at 76a-77a. The remaining five state-law duties all have clear analogues under the Medicare Act, see, *e.g.*, 42 C.F.R. § 417.101(a) (requiring Medicare provider to provide appropriate referrals); *id.* §§ 417.479, 422.206, 422.208 (limitations on physician incentive plans); *id.* §§ 417.617, 417.609, 422.570 (expediting certain beneficiary appeals); *id.* §§ 417.418, 417.106, 422.152 (requiring quality assurance program for Medicare providers); *id.* §§ 417.460, 417.461, 422.74 (providers' duties with respect to disenrolling a beneficiary). The remaining counts expressly relied on the alleged violations of the duties enumerated in Count 1.[5] The critical point is this: Each count was based on alleged

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[5] Count 2 alleges that petitioners *willfully* "failed to secure for GEORGE [McCall] the health care services he reasonably needed, including a lung transplant" and failed to fulfill the other duties set forth in Count 1. App. 79a. Counts 3, 4, 5, and 6 allege that to qualify as Medicare providers and to induce McCall to enroll, petitioners made misrepresentations and perpetrated a fraud upon the government and McCall by stating that they would fulfill the duties set forth in Count 1. *Id.* at 80a-90a. Counts 7 and 8 allege that petitioners' failure to fulfill their duties under Count 1 and their misrepresentations and fraud concerning the same constitute intentional and negligent infliction of emotional distress. *Id.* at 90a-92a; *see also* 42 C.F.R. §§ 417.124, 422.111, 422.210(b). Finally, Count 9 alleges that petitioners' failure to fulfill their duties under Count 1 and their misrepresentations and fraud concerning the same are unfair business practices and should be enjoined. App. 92a-93a.

violations of duties under the Medicare Act, most notably the duty to provide coverage for a lung transplant at UCSD.

PacifiCare and GNP demurred on the ground that the McCalls' claims arose under the Medicare Act, and therefore that jurisdiction lies exclusively in federal court and only after exhaustion of the administrative process for review of claims arising under the Act. See 42 U.S.C. § 405(g), (h). The trial court sustained the demurrers on the grounds pled, and dismissed the McCalls' claims against PacifiCare and GNP. Dr. Shukla did not file a demurrer, and the court did not dismiss the action as against him. App. 42a n.1.

3. The Court of Appeal reversed in part. It acknowledged that "[t]he gravamen of [the McCalls'] complaint is that, to save money, Pacificare, GNP and Shukla, repeatedly refused to refer him to a specialist for a lung transplant, or provide other needed care, and ultimately forced him to leave the plan to get on the list for a transplant . . . . [and that] [d]uring that time his condition worsened." App. 41a. The court further recognized that if "[the McCalls' claims arose under the Medicare Act], they were required to first exhaust their administrative remedies and could thereafter only seek judicial review in federal court." *Id.* at 43a. Finally, the court understood that a claim arises under the Medicare Act whenever "'"both the standing and the substantive basis for the presentation"'" of a claim is the Medicare Act or when a claim is "'"inextricably intertwined"'" with an alleged violation of duties under the Medicare Act. *Id.* at 44a, 45a (quoting *Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984), and *Redmond* v. *Secure Horizons, Pacificare, Inc.*, 60 Cal. App. 4th 96, 102 (1997)).

The Court of Appeal nonetheless held that although the McCalls' claims "*depend* upon entitlement to benefits under the Medicare Act," App. 45a, they did not arise under the Medicare Act. The court held that "[w]here a state law claim is brought against an HMO, even if the claim is based on a denial of Medicare benefits, federal courts distinguish

Heckler and allow the action to proceed in state court." *Id.* at 45a-46a (citing cases). "[S]tate law claims which do not seek reimbursement for Medicare benefits do not arise under the Medicare Act, and are actionable in state court." *Id.* at 47a. The court held that the McCalls should have been permitted to amend their complaint to eliminate claims for past and future medical expenses as damages and that, once they did so, the claims would not arise under the Medicare Act. *Id.* at 47a & n.2.[6]

4.(a) The Supreme Court of California granted PacifiCare's and GNP's petitions for review, but a divided court ultimately affirmed the decision of the Court of Appeal. Like the Court of Appeal, the supreme court recognized that the critical question was whether the McCalls' claims arise under the Medicare Act, because such claims "may be reviewed by no person, agency or tribunal except in an action brought in federal district court, and then only after exhausting administrative remedies as described above." App. 5a.

But, the supreme court held that the McCalls' claims did not arise under the Medicare Act, even though they were premised on the alleged violations of duties under that Act, because the McCalls did not seek reimbursement of benefits as damages and because their "alleged harms" could not "be remedied through the Medicare administrative review process." App. 12a. The court acknowledged that the HMO's rationale – "i.e., that the plaintiff's state tort law claims were inextricably intertwined with a Medicare claim because the alleged wrongfulness of the defendant's conduct depended on whether the plaintiff was, in fact, entitled to payment of her claim – has a certain logic." *Id.* But the court relied on a presumption that Congress did not intend to

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[6] The court also held that, under state law, PacifiCare and GNP may be vicariously liable for the negligence of a member physician. App. 48a-50a. That holding, which was affirmed by the Supreme Court, *id.* at 19a, is not at issue in this petition.

preempt state regulation of the same subject matter "unless a contrary intent is made clear." *Id.* It found that "[n]o intent to displace state tort law remedies was expressed in the Medicare Act as it read at the time relevant to this case" and that the subsequent Balanced Budget Act of 1997 reinforced this conclusion by preempting only "state laws mandating benefits to be covered, mandating inclusion of providers and suppliers, and coverage determinations." *Id.* at 13a, 14a.

In a final footnote, the court attempted to distinguish contrary federal court of appeals cases, stating that the latter were "actions seeking tort damages for harm allegedly sustained as a result of improper denial of claims, not, as here, claims arising from violations of duties separate from the duty to pay Medicare benefits." App. 19a n.11.

(b) Two justices dissented. As their opinion summarized:

> Disregarding th[e] congressional mandate [that all denials of Medicare claims be reviewed through Medicare's administrative review process and then in federal court] and key United States Supreme Court authority, the majority opinion allows virtually any Medicare HMO plan enrollee to bring suit in state court to challenge an HMO's denial of Medicare benefits. Enrollees may bypass Medicare's exhaustion requirements simply by styling their challenges as claims for tort damages. As a result, questions regarding which medical procedures are or should be covered by Medicare may now be decided outside of Medicare's exclusive review process by California judges and juries on an ad hoc basis.
>
> . . . [T]oday's decision sets the stage for potential conflict between an award of state law tort damages following a determination in a state court that Medicare benefits were wrongly denied, on the one hand, and the possibility that an exhaustive administrative appeal, followed by federal court review, would determine that

> Medicare benefits were *not wrongly denied* in the particular case and in other comparable cases, on the other. The two cannot be squared . . . . [App. 20a.]

The dissent explained that "[t]aken together," this Court's decisions in *Heckler* v. *Ringer* and *Weinberger* v. *Salfi* "make clear that claims challenging an HMO's denial of reasonable and necessary health services covered by Medicare must undergo an administrative review for final decision prior to any judicial review to ensure Medicare's efficient and orderly functioning." App. 26a. Pertinent here, in rejecting the argument that the McCalls' claims arose under state tort law and *not* under the Medicare Act, the dissent relied on this Court's rejection of the analogous argument in *Salfi*. See *id.* (citing *Weinberger* v. *Salfi*, 422 U.S. 749, 764 (1975)) (holding that the beneficiary's claim arose under both the Constitution and the Social Security Act).

The dissent also relied on this Court's explanation that "'the purpose of the exhaustion requirement is to prevent "premature interference with agency processes" and to give the agency a chance "to compile a record which is adequate for judicial review."'" App. 26a (quoting *Ringer*, 466 U.S. at 619 n.12, quoting *Salfi*, 422 U.S. at 765). "That purpose is frustrated substantially when HMO plan enrollees are permitted to bypass the administrative process," because "'plaintiffs in effect call upon the court to play doctor in their cases. The prescribed HMO and agency decisionmaking procedures were designed to avoid that problem.'" *Id.* at 27a (quoting *Roen* v. *Sullivan*, 764 F. Supp. 555, 560-61 (D. Minn. 1991)).

The dissent further explained that the majority decision put the California Supreme Court in conflict with federal court of appeals decisions foreclosing state law claims relating to benefit reimbursement by Medicare contractors. These decisions make clear that a plaintiff cannot avoid the exhaustion requirement "'simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits,'" even though that

administrative process might not afford the plaintiff full relief. App. 28a (quoting *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 487 (7th Cir. 1990)).

Under this authority, the dissent argued, the McCalls' claims arise under the Medicare Act:

> Critically, plaintiffs' ability to prevail on their state law causes of action inevitably turns upon a determination that plaintiff George McCall was entitled to a Medicare benefit, i.e., a lung transplant, and that PacifiCare had no right to deny such benefit because it was reasonable and necessary for treatment of his condition. The consequential damages sought by plaintiffs also are dependent upon such a determination. That being the case, plaintiffs' claims are "inextricably intertwined" with a Medicare benefits determination and are subject to Medicare's administrative review process. [App. 31a (citations omitted).]

See also *id.* at 33a ("the harm resulting from all of PacifiCare's alleged misconduct is inseparable from the harm resulting from its denial of the lung transplant [so] there appears no basis for finding any of the claims exempt from the administrative review process"). The majority's disregard of these points, the dissent stated, "all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review." *Id.* at 39a.

REASONS FOR GRANTING THE PETITION

Each of the McCalls' state law claims rests on an allegation that PacifiCare and GNP breached duties under the Medicare Act, primarily the duty to provide George McCall with a medically "reasonable and necessary" health service (a lung transplant), and that these failures injured him. The California Supreme Court held that state law claims "arising out of [a Medicare contractor's] refusal to provide services under a Medicare-subsidized health plan," App. 1a, do not "aris[e] under" the Medicare Act, 42 U.S.C. § 405(h), where

the Medicare beneficiary does not seek Medicare benefits as damages and cannot obtain complete relief through the Medicare review process. The court is wrong, and its error broadens an extant conflict in the lower courts, contravenes this Court's legal framework for determining when a claim arises under the Medicare Act, and endangers and disrupts the Medicare program.

In reaching its decision, the California court acknowledged that "some disagreement exists among state and federal courts on this question, which has not yet been addressed by the United States Supreme Court." App. 1a. It chose to follow the line of authority exemplified by the Ninth Circuit's decision in *Ardary* v. *Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996). By doing so, it brought itself into conflict with decisions of three other Circuits holding that state and federal law claims dependent upon the lawfulness of Medicare determinations arise under the Medicare Act. See *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, 903 F.2d 480, 487-88 (7th Cir. 1990); *Midland Psychiatric Assocs., Inc.* v. *United States*, 145 F.3d 1000, 1003 (8th Cir. 1998); *Affiliated Prof'l Home Health Care Agency* v. *Shalala*, 164 F.3d 282, 285 (5th Cir. 1999). These courts have explained that "a party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a [state and federal law] claim for collateral damages instead of a challenge to the underlying denial of benefits" or "the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." *Bodimetric*, 903 F.2d at 487.

Moreover, the California decision cannot be reconciled with this Court's jurisprudence concerning subsections 405(g) and (h) and the administrative channeling requirement of the Medicare Act. Specifically, the California court held that the McCalls' claims need not be channeled for three reasons: (i) because they arise under state laws; (ii) because the McCalls do not seek Medicare benefits as damages; and (iii) because

the McCalls could not receive the consequential damages they seek in the administrative process. This Court, however, has expressly stated that none of these factors justifies circumvention of the administrative process. See *Heckler* v. *Ringer*, 466 U.S. 602, 618-19 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 765 (1975); *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000); *Schweiker* v. *Chilicky*, 487 U.S. 412, 423 (1988). Instead, the Court has interpreted the channeling requirement broadly "to assure[] the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts." *Illinois Council on Long Term Care*, 529 U.S. at 13.

It was Congress' statutory scheme that occasioned this Court's forebearance. Medicare is a vast and complex federal program which provides health insurance coverage for approximately 39 million persons, see *infra* at 25, and the administrative channeling requirement is a critically important component of the program. The California court's roadmap for avoiding the administrative process will have profound and profoundly damaging consequences:

First, it allows virtually all Medicare beneficiaries to bring suit in state court to challenge a Medicare contractor's denial of Medicare benefits "simply by styling their challenges as claims for tort damages." App. 20a. Under the California court's regime, judges and juries will provide the initial review of Medicare benefits determinations and consequential damages may be awarded, directly contravening the congressional mandate of limited judicial review and remedies and dramatically increasing both the amount of litigation and the price tag of the Medicare program. *Second*, the decision effectively forecloses uniform interpretation and enforcement of Medicare. It permits inconsistent and fundamentally unfair treatment of similarly-situated beneficiaries, based on whether they seek administrative review or file a lawsuit and based on the state or federal

circuit in which they reside. *Finally*, if the decision is interpreted to apply only to *HMO* Medicare providers, it creates a relative disadvantage for such providers at a time when Congress has decided to encourage provision of Medicare benefits through managed care. The substantial harm that the decision inflicts on a central component of an important federal program warrants this Court's review.

All of this damage, moreover, is achieved by an erroneous and crabbed interpretation of the requirement that all claims "arising under" the Medicare Act be administratively exhausted. 42 U.S.C. § 405(h). A state law claim arises under the Medicare Act if it is "inextricably intertwined" with a Medicare benefits claim. *Ringer*, 466 U.S. at 614-15. Under this definition, claims that are predicated on the unlawfulness of a provider's conduct under the Medicare Act plainly arise under the Medicare Act within the meaning of section 405(h). The California Supreme Court's contrary conclusion "all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review," App. 39a, in contravention of congressional intent and this Court's precedent and with drastic, damaging effect on the Medicare program.

For all of these reasons, this Court should grant the petition for review.

I. THE CALIFORNIA SUPREME COURT'S DECISION CONFLICTS WITH DECISIONS OF THE FEDERAL COURTS OF APPEALS AND OF THIS COURT AND IS WRONG.

Recognizing that "some disagreement exists among state and federal courts on this question which has not yet been addressed by the United States Supreme Court," the California Supreme Court held that state and other federal claims "arising out of [a Medicare provider's] refusal to provide services under a Medicare-subsidized health plan" do *not* fall within Medicare's exclusive review provisions so

long as the beneficiary does not seek to recover Medicare benefits as damages and cannot obtain complete relief through the Medicare Act's administrative process. App. 1a. This decision – which allows Medicare beneficiaries to avoid the administrative exhaustion requirement of the Medicare Act "simply by styling their challenges as claims for tort damages," *id.* at 20a – widens a substantial and important conflict in the judicial interpretation of the Medicare Act and is in irreconcilable tension with decisions of this Court.

1. There is now a broad, established conflict among the lower courts on the question whether state and other federal claims that are predicated upon a finding that Medicare benefits were wrongly denied "arise under" the Medicare Act, or whether such claims are collateral to claims under the Medicare Act as long as the beneficiary does not seek benefits as damages and cannot obtain complete relief in the Medicare administrative process.

The principal case holding that state and other federal law claims dependent upon a Medicare benefits determination arise under the Act is *Bodimetric Health Services, Inc.* v. *Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990). There the plaintiff, Bodimetric, brought state and federal law claims of, *inter alia*, fraud, fraudulent concealment, negligent misrepresentation, breach of contractual relationship, and civil RICO against Aetna, a carrier under contract with HCFA to administer Medicare claims. Bodimetric alleged that Aetna adopted a restrictive approach to Bodimetric's Medicare claims, leading to the wrongful denial of many such claims and the consequent closure of many of Bodimetric's home health agencies. *Id.* at 482. Aetna moved to dismiss for lack of subject matter jurisdiction, asserting that Bodimetric's claims arose under the Medicare Act and thus had to be administratively exhausted. *Id.* at 483.

Relying on this Court's instruction that "the term 'arising under' [should be read] broadly," and that "claims arising under other statutes may be barred by section 405(h) if they

are also 'inextricably intertwined' with the benefits determinations under the Medicare Act," the Seventh Circuit agreed that exhaustion was required. *Id.* (quoting *Ringer*, 466 U.S. at 622-24). In words apposite here, the court held that:

> *[a] party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits.* If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." [*Id.* at 487 (emphasis supplied).][7]

The court specifically rejected Bodimetric's arguments that its claims did not arise under the Act because it could not receive full relief for its state law tort and contract claims through the administrative process: "[T]o be sure, the ALJ reviewing a denied claim may consider substantively different

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[7] As the Government explained in its Brief to the Seventh Circuit in *Bodimetric*:

> Plaintiffs cannot establish their case without addressing either directly or indirectly the correctness of Aetna's denials of the disputed claims because the amended complaint alleges that Aetna denied claims improperly and because the consequential damages plaintiffs seek to recover flow from the impropriety of the denials of the claims. Furthermore, . . . in any event Aetna would be entitled in defense of this action to establish that the denials of reimbursement in some or all of the claims that underlie the amended complaint were correct. [Brief of United States at 4, *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, 903 F.2d 480 (9th Cir. 1990) (Nos. 89-1428, 89-1570) (citations omitted).]

Thus, the Government argued, the claims are "inextricably intertwined with whether Aetna's determinations of benefits as to these claims were correct. Plaintiff cannot alter that reality by the artifice of calling the amounts of the denied claims 'damages' and seeking to recover them from Aetna instead of from the Secretary." *Id.* at 5.

issues than might a state or federal judge reviewing a tort or contract claim, but the ALJ can provide relief to Bodimetric through the reversal of denied claims." *Id.* While the administrative process "may not afford Bodimetric all the relief it seeks pursuant to its state law claims," "Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process." *Id.* at 487 n.5.

Similarly, in *Midland Psychiatric Associates, Inc.* v. *United States*, 145 F.3d 1000 (8th Cir. 1998), the plaintiff, Midland, brought claims for tortious interference with contract against Mutual of Omaha Insurance Company and for negligent supervision of contract under the Federal Tort Claims Act against the United States, based on Mutual's allegedly deliberate denial of Medicare claims in order to put Midland out of business. *Id.* at 1002. The court concluded "that hearing Midland's tortious interference claim against Mutual would mean reviewing the merits of Mutual's Medicare claims decisions"; that Midland's claim therefore arose under the Medicare Act; and that the court lacked jurisdiction to consider the claim because Midland had failed to exhaust its administrative remedies. *Id.* As the court explained, "[a] claim may arise under the Medicare Act even though, as pleaded, it also arises under some other law." *Id.* at 1004 (citing *Salfi*, 422 U.S. at 760-61). "[H]earing Midland's tortious interference claim would necessarily mean redeciding Mutual's Midland-related Medicare claims decisions," the court concluded, and the claim therefore arises under the Medicare Act and must be administratively exhausted. *Id.* See *id.* at 1005 (holding that Midland's negligent supervision claim against the United States arose under the Medicare Act because it alleged that the government negligently "allowed Mutual to deny Medicare claims wrongfully").

Finally, the Fifth Circuit, too, has made clear that a claim arises under the Medicare Act where, as here, a state or federal claim depends upon a decision subject to exhaustion

under the Medicare Act. In *Affiliated Professional Home Health Care Agency* v. *Shalala*, 164 F.3d 282 (5th Cir. 1999), APRO filed a lawsuit claiming that the defendants conspired to violate its right to due process and equal protection under the Constitution by arbitrarily terminating its status as a Medicare provider because it is an African-American owned enterprise. The court declared that:

> [T]o fully address APRO's claim that their due process and equal protection rights were violated through the improper enforcement of Medicare regulations, a court would necessarily have to immerse itself in those regulations and make a factual determination as to whether APRO was actually in compliance. Given the administrative nature of that inquiry, it cannot be reasonably concluded that APRO's claim is collateral to a claim for administrative entitlement. [*Id.* at 285.]

The court concluded that "there is little doubt that APRO's claim is 'inextricably intertwined' with a demand for benefits," and thus dismissed APRO's complaint pursuant to section 405(g). *Id.* at 286. See also *Wilson* v. *Chestnut Hill Healthcare*, No. Civ. A. 99-CV-1468, 2000 WL 204368, at *4 (E.D. Pa. Feb. 22, 2000) (mem.) ("courts must discount any 'creative pleading' which may transform Medicare disputes into mere state law claims, and painstakingly determine whether such claims are ultimately Medicare disputes").[8]

Each of the above cases reflects the respective court's recognition that where "a necessary element of [a] cause of action is a showing that [the provider's] decisions concerning the amount of benefits due on the claims at issue were *incorrect* under the Medicare Act," the claim "plainly does involve the 'amount of benefits' payable under the Medicare

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[8] *Cf. Jamaica Hosp. Nursing Home* v. *Oxford Health Plans*, No. 99 CIV. 9541, 2000 WL 1404930, at *3 (S.D.N.Y. Sept. 26, 2000) (holding that claim for benefits presented as a contract claim arises under the Medicare Act).

Act," and must be channeled through the Act's administrative processes and judicial review provision. See United States' Brief in Opposition to the Petition for Certiorari at 12, *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, No. 90-328 (U.S. filed Nov. 1990) ("United States' *Biometric* Opp."). In this case, however, the California Supreme Court rejected this legal framework and instead adopted the Ninth Circuit's approach in *Ardary*. See App. 8a-17a.

In *Ardary*, the heirs of a deceased Medicare beneficiary brought a state law tort action against a Medicare provider seeking compensatory and punitive damages (but not Medicare benefits), on the grounds that the provider improperly denied emergency medical services (an airlift to a superior hospital) and misrepresented its plan to the beneficiary. The provider moved to dismiss on the ground that the claims arose under the Medicare Act and therefore that the claims had to be administratively exhausted, but the court of appeals rejected its arguments for two reasons: First, the court held that the standing and substantive bases for the claims were "state common law theories and not the [Medicare] Act." 98 F.3d at 499-500. Second, "[a]lthough the [plaintiffs] concede[d] that their wrongful death complaint [wa]s 'predicated on' [the provider's] failure to authorize the airlift transfer," the court concluded that the state law claims were not "'inextricably intertwined' with the denial of benefits because the [plaintiffs] [we]re at bottom not seeking to recover benefits" and because the death of the beneficiary could "not be remedied by the retroactive authorization of payment of the airlift transfer." *Id.* at 500.

Similarly, in this case, despite recognizing the "logic" of the argument that a state tort law claim is inextricably intertwined with the Medicare Act where "the alleged wrongfulness of the defendant's conduct depend[s] on whether the plaintiff was, in fact, entitled to payment of [the] claim," the California Supreme Court rejected it. App. 12a. Instead, the court followed *Ardary* and determined that where

a beneficiary does not seek to recover benefits and where the harms suffered by the beneficiary cannot be remedied through the administrative process, the claims are merely collateral or incidental to the claim for Medicare benefits, do not arise under the Medicare Act, and need not be administratively exhausted. *Id.* See also *Plocica* v. *Nylcare of Texas, Inc.*, 43 F. Supp. 2d 658, 663-64 (N.D. Tx. 1999); *Wartenberg* v. *Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273, 278-79 (E.D.N.Y. 1998).

There is now a stark and mature conflict among the lower courts on the issue presented by this case – whether state law claims that depend upon alleged violations of duties under the Medicare Act arise under that Act where the beneficiary does not seek benefits and could not obtain consequential damages in the Medicare administrative process. Particularly in light of the substantial importance of this question to the Medicare system and Medicare beneficiaries, see Part II *infra*, this Court should resolve the conflict.

2. The California Supreme Court's decision is also in irreconcilable tension with this Court's decisions in *Heckler* v. *Ringer*, 466 U.S. 602 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749 (1975); *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000); and *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and therefore is both worthy of review and wrong. Specifically, the decision rests on premises that this Court has emphatically rejected in its cases interpreting subsections 405(g) and (h); and the result is fundamentally inconsistent with the analysis in those cases and their mandate that the phrase "arising under" be construed broadly, *Ringer*, 466 U.S. at 615.

First, the California court concluded that the claims at issue arise under state law and thus could not also arise under the Medicare Act. App. 15a. But, this Court has made clear that claims may arise under the Medicare Act, and thus be subject to its administrative processes, even though they also arise under some other law. See *Ringer*, 466 U.S. at 615

(explaining that a claim may arise under the Medicare Act even though it is "in one sense also a claim arising under the Constitution"); *Salfi*, 422 U.S. at 760 (holding that although "[i]t would . . . be fruitless to contend that appellees' claim is one which does not arise under the Constitution," it would be equally fruitless "to argue that this action does not also arise under the [Act]").

Second, the California Supreme Court concluded that the state law claims at issue did not arise under the Medicare Act because the plaintiffs did not seek benefits or reimbursement of benefits, but instead sought consequential damages for the violation of state law duties resulting from the denial of benefits and other alleged violations of McCall's rights under the Medicare Act. But, this Court made clear in *Ringer* that a Medicare beneficiary must administratively exhaust a claim arising under the Act even if the beneficiary does not seek payment of benefits as relief. In that case, one of the plaintiffs lacked a valid claim for reimbursement because he had not undergone the operation at issue and did not intend to do so unless a court set aside as unlawful the agency's "no reimbursement" determination. 466 U.S. at 614-16. This Court nonetheless held that his claim required a determination of his entitlement to benefits under the Medicare Act, arose under the Act, and had to be channeled through the administrative process. See *id.* at 623 ("today we explicitly hold that our conclusion that the claims of [the beneficiaries] are barred by § 405(h) is in no way affected by the fact that those respondents did not seek an award of benefits"); *Illinois Council on Long Term Care*, 529 U.S. at 12 (channeling is required "despite the absence of any request for [benefits]").

Third, the California Supreme Court concluded that no exhaustion is required when a beneficiary cannot receive consequential damages or other tort-based relief through the administrative process. But *Illinois Council on Long Term Care* also made clear that a claim arising under the Medicare Act must be exhausted even though the Secretary cannot

address all claims and provide all remedies sought by the plaintiffs:

> The fact that the agency might not provide a hearing for that *particular contention*, or may lack the power to provide one, is beside the point because it is the "action" arising under the Medicare Act that must be channeled through the agency. See *Salfi*, *supra* at 762. After the action has been so channeled, the court will consider the contention when it later reviews the action. And a court reviewing an agency determination under § 405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot, decide, including, where necessary, the authority to develop an evidentiary record. [529 U.S. at 23-24 (string citations omitted).]

See also *Chilicky*, 487 U.S. at 428-29 (holding that even where administrative remedies do not provide complete relief for the beneficiary, both the alleged constitutional violation and the denial of benefits from which it arises are remediable, if at all, only through the federal administrative review process); *Matthews* v. *Eldridge*, 424 U.S. 319, 329-31 (1976) (holding that a beneficiary must present his claimed entitlement to benefits administratively and that a court may thereafter consider a constitutional challenge related to that entitlement). Cf. *Booth* v. *Churner*, 121 S. Ct. 1819, 1822 (2001) (inmate raising claim "with respect to prison conditions" and seeking only money damages must nonetheless exhaust administrative review process which cannot provide such relief).

Petitioners readily acknowledge that this Court has never expressly held that a state or other federal law claim predicated on the denial of Medicare benefits or other rights under the Medicare Act and seeking consequential damages rather than benefits "arise[s] under" the Medicare Act. This Court's legal framework for determining whether a claim

arises under the Medicare Act, however, simply cannot accommodate the decision below in this case.

Under this Court's decisions, the statutory mechanism for administrative and judicial review in the Medicare Act furnishes comprehensive and exclusive remedies for all claims "arising under" the Medicare Act. 42 U.S.C. § 405(h). This Court has made clear that direct judicial review is unavailable for claims "arising under" the Medicare Act; that the term "arising under" must be interpreted "quite broadly"; and that a claim arises under the Medicare Act where "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act or where the claim is "inextricably intertwined" with a claim for Medicare benefits. *Ringer*, 466 U.S. at 615, 614. The joint effect of these statutory provisions as construed by this Court is preclusion of collateral attacks on Medicare Act determinations in independent lawsuits against Medicare contractors.

A state or other federal law claim that is predicated upon the unlawfulness of a Medicare benefits determination or the violation of other duties under the Medicare Act plainly "arises under" the Medicare Act, as interpreted by this Court. Here, the McCalls clearly could not recover damages for injuries allegedly sustained as a result of petitioners' actions without proving that petitioners wrongly determined that George McCall was not eligible for a lung transplant and violated other rights he possessed under the Medicare Act. For example, in order to establish his negligence claim, McCall would have to show that petitioners violated one of the duties owed to him, as alleged in Count 1 of the complaint. To determine the nature and scope of those duties, the state court would have to interpret and apply the Medicare statute and regulations. See *supra* at 5 (laying out the Medicare provisions establishing each of the duties alleged to have been violated in Count 1). The "intertwined" inter-relationship between McCall's claims and the Medicare program necessarily precludes judicial review of those claims

except after administrative consideration (and even then only in federal court).[9] Were the rule otherwise, Congress' channeling requirement and all of the purposes served thereby could be rendered meaningless.

Petitioners most certainly do not contend that a tort challenge to quality of care (such as a medical malpractice claim) would have to be channeled pursuant to subsections 405(g) and (h). But where, as here, the Medicare contractor makes a determination of eligibility for a Medicare benefit – *viz.*, a determination whether a particular service such as a lung transplant is medically reasonable and necessary – challenges to that eligibility determination must be administratively channeled under the Medicare Act. Cf. *Pegram* v. *Herdrich*, 530 U.S. 211, 229 (2000) (holding that challenges to a physician's pure treatment decisions that may affect eligibility are not preempted by ERISA, but that challenges to an HMO's eligibility decisions which "turn on the [ERISA] plan's coverage of a particular condition or medical procedure for its treatment" are preempted).

The California Supreme Court's decision, accordingly, not only broadens the existing conflict among the federal courts concerning whether state claims that are predicated upon a wrongful denial of benefits arise under the Medicare Act, it

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[9] This conclusion is further reinforced by the language of section 405(h) which states that "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided." 42 U.S.C. § 405(h) (emphasis supplied). The McCalls effectively asked the state "tribunal" to "review[]" the unappealed eligibility and other Medicare-related decisions that petitioners made on behalf of the Secretary. *See id.* This is not the route "provided" for judicial review in the Medicare Act. *See also id.* (forbidding federal court to exercise diversity jurisdiction over claims arising under the Act); *Bodimetric*, 903 F.2d at 488-89 (same).

also conflicts with the logic of long standing precedent of this Court.[10]

* * * *

Review should be granted both to resolve the conflict among the lower courts on the nationally important question

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[10] The California Supreme Court's decision is also in substantial tension with this Court's decisions defining the term "arising under" in other contexts. In interpreting the scope of federal question jurisdiction under 28 U.S.C. § 1331, this Court has long held that a state law claim arises under federal law when "federal law creates the cause of action or . . . the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." *Franchise Tax Bd. of Cal.* v. *Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 27-28 (1983). Indeed, under the rule established in *Smith* v. *Kansas City Title & Trust Co.*, 255 U.S. 180, 199 (1921) and oft repeated, it is settled that "arising under" jurisdiction exists where the plaintiff's "right to relief depends upon the construction or application of the Constitution or laws of the United States," even though the right asserted and the remedy sought by the plaintiff are State-created. *See also* C. Wright, *Law of Federal Courts* § 17, at 95-96 (4th ed. 1983); *Merrell Dow Pharms., Inc.* v. *Thompson*, 478 U.S. 804, 808-10 (1986). Consistent with this Court's interpretation of the same term in section 1331, the question whether the McCalls' claims arise under the Medicare Act turns on whether the McCalls' right to relief depends upon the construction or application of rights and duties under the Medicare Act. Plainly, it does. *See supra* at 5.

The Court has also often considered whether a state law tort or contract claim arises under section 301(a) of the Labor Management Relations Act, 29 U.S.C. § 185(a), which provides federal jurisdiction for suits for violation of collective bargaining agreements. Most recently, in *United Steelworkers* v. *Rawson*, 495 U.S. 362 (1990), this Court held that a claim arises under section 301 if it is based on a duty created by a collective bargaining agreement or otherwise "substantially dependent" upon the construction of a collective bargaining agreement and that this result cannot be avoided by characterizing a claim as a state law tort. *Id.* at 366-67, 371 (citing *International Bhd. of Elec. Workers* v. *Heckler*, 481 U.S. 851 (1987); *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202 (1985)). Similarly here, McCall's state law claims are "substantially dependent" upon the lawfulness of a Medicare benefits determination and thus arise under the Medicare Act.

presented and to forestall serious damage to this Court's established legal framework for analysis of subsections 405(g) and (h).

II. THIS DECISION IS VITALLY IMPORTANT TO THE MEDICARE PROGRAM AND HENCE TO MILLIONS OF AMERICANS.

In 2000, Medicare provided health insurance coverage for 39 million persons (one in seven Americans) and paid $217 billion in benefits. App. 20a (citing The Henry J. Kaiser Family Found., *Medicare At A Glance* 1 (Feb. 2001)). The importance of this case to the future administration of Medicare and, indeed, of Social Security generally[11] cannot be overstated. It has long been settled law that Medicare beneficiaries cannot sue Medicare carriers or fiscal intermediaries for claims "arising under" the Medicare Act without first exhausting their administrative remedies; moreover, the relief available to the beneficiary has generally been limited to an award of benefits. 42 U.S.C. § 405(g), (h). The California Supreme Court decision, however, creates a different rule – one that permits direct judicial review, with no limitation on remedies for Medicare beneficiaries. If this decision stands, the consequences for Medicare will be devastating.

First, as the dissent explained:

> [The decision] allows virtually any Medicare HMO plan enrollee to bring suit in state court to challenge an HMO's denial of Medicare benefits. . . . simply by styling their challenges as claims for tort damages. As a result, questions regarding which medical procedures are

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[11] Subections 405(g) and (h) apply to claims arising under both the Medicare Act and the Social Security Act generally. *See, e.g., Salfi*, 422 U.S. at 760-61, 763. Thus, the damaging impact of the California court's decision will extend not only to Medicare, but also to the Social Security program generally.

> or should be covered by Medicare may now be decided outside of Medicare's exclusive review process by California judges and juries on an ad hoc basis. [App. 20a.]

Thus, under the California decision, judges and juries – not HCFA and the Secretary – will provide the initial review of benefit determinations made by HMOs contracting with Medicare. This result severely undermines the Medicare Act's mandate of administrative determination of Medicare claims with only limited judicial review. See *Ringer*, 466 U.S. at 619 n.12 ("the purpose of the exhaustion requirement is to prevent 'premature interference with agency processes' and to give the agency a chance 'to compile a record which is adequate for judicial review'") (quoting *Salfi*, 422 U.S. at 765); *Illinois Council on Long Term Care*, 529 U.S. at 24 ("[p]roceeding through the agency in this way provides the agency the opportunity to reconsider its policies, interpretations, and regulations in light of th[e] challenges"). Instead, contrary to congressional intent, judges and juries will "play doctor." App. 27a.

Second, the consequential damages resulting from a delay or denial of benefits may be significantly greater than the value of the Medicare benefits lost in many situations. The court's decision, accordingly, will be a strong inducement to litigation and substantially increase the costs of administering the Medicare program. Almost certainly, Medicare contractors will begin to authorize unwarranted benefits to avoid litigation based on their refusal to do so and the risk of judgments that include consequential damages. This outcome contravenes the congressional decision to limit litigation and confine remedies to those provided under the Act, which reflects a careful balancing of competing private and governmental interests. See *Chilicky*, 487 U.S. at 426; *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 n.11 (1982) (the legislative history of section 1395ff shows that "the remedies provided by these review procedures shall be exclusive") (quoting S. Rep. No. 89-404, at 54-55 (1965) (emphasis omitted)).

> While the Medicare system may not afford the range of relief available under state law, it is designed to provide that coverage decisions are reviewed in a thorough and expeditious manner by HCFA or its agent, and by ALJ's and departmental review boards that have special expertise in such matters. It is not the prerogative of this court to second-guess the measured tradeoffs enacted by Congress. [App. 39a.][12]

If the rule established in the decision below survives:

> Virtually any disappointed Medicare or other Social Security claimant could recast his challenge to an administrative decision denying his claim for benefits into a challenge to conduct underlying that decision – and then seek damages for the underlying conduct. Allowance of state-law damage actions in these circumstances would therefore invite widespread disruption of the Medicare Program and other Social Security programs, divert scarce resources to such litigation, and result in monetary remedies beyond those Congress intended – thereby giving rise to either a drain on the Medicare Trust Fund to pay such judgments against intermediaries or (if the United States did not make the intermediaries whole) a substantial disincentive for organizations to take on the task of serving as an intermediary. [United States' *Bodimetric* Opp. at 18.]

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[12] Indeed, as the dissenting California Supreme Court justices observed, in reviewing Medicare benefits claims, the Secretary may impose in addition to "'any other remedies authorized by law,'" civil monetary penalties and may suspend payment to or enrollment of a contracting HMO where, *inter alia*, the HMO "'fails substantially to provide medically necessary items and services that are required (under law or under the contract)'" or "'misrepresents or falsifies information that is furnished – [] . . . to the Secretary . . . or [] . . . to an individual'" App. 22a (omissions in original) (quoting 42 U.S.C. § 1395mm(i)(6)(A)(i) & (v)).

Cf. also *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 511-12 (1988) ("[t]he financial burden of judgments against the [government] contractors would ultimately be passed through, substantially if not totally, to the United States itself, since . . . contractors will predictably raise their prices to cover, or to insure against, contingent liability"). This decision, in short, will have a dramatic impact on federal funding of Medicare.

Congress and the current administration have recently made clear their determination to increase the number of Medicare beneficiaries in managed care.[13] But, under the California decision, the litigation and the costs entailed in providing benefits to Medicare beneficiaries will dramatically increase, and managed care contractors (already reluctant participants)[14] will be increasingly unwilling to provide Medicare benefits.

Third, there is a strong federal interest in the uniform interpretation of federal statutes generally, and the need for uniform determinations of benefits and rights under the Medicare Act is particularly compelling. The decision at issue inflicts substantial damage on the federal interest in the uniform interpretation and enforcement of the Medicare Act in two different respects.

Initially, it creates the very real possibility that a state court might award a Medicare beneficiary damages based on its view that benefits were wrongly denied, while "an exhaustive

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[13] *See, respectively*, Balanced Budget Act of 1997, 42 U.S.C. § 1395mm(k) (enacting a new range of Medicare managed choice options effective January 1, 1999); Robert Pear, *Medicare Shift Toward H.M.O.'s Is Planned*, N.Y. Times, June 5, 2001, at A17 (reporting HCFA's announcement of the administration's determination to increase the number of Medicare beneficiaries in managed care).

[14] *See* Pear, *supra* ("[m]any H.M.O.'s have reduced their participation in Medicare, calling payments inadequate and regulations excessive. In the last three years, managed care plans have dropped more than 1.6 million Medicare beneficiaries").

administrative appeal, followed by federal court review, would determine that Medicare benefits were *not wrongly denied* in the particular case and in other comparable cases." App. 20a. A particular beneficiary thus could receive a substantial jury award based on a determination that Medicare benefits were wrongly denied or delayed while a similarly situated beneficiary who pursued an unsuccessful administrative appeal would receive nothing. Such a result is entirely antithetical to Congress' determination to create a federal benefit consistently administered and to secure that end by requiring that all claims arising under the Medicare Act be channeled through the administrative process. See *Illinois Council on Long Term Care*, 529 U.S. at 24 ("[p]roceeding through the agency in this way provides the agency the opportunity to reconsider its policies, interpretations and regulations in light of th[e] challenges").

Moreover, under the California decision, the varied law of individual states – rather than uniform federal law – will determine both whether a benefit should be provided and what the remedy should be for a failure to do so. This will result not only in increased state and federal court litigation, but also in unseemly forum shopping. A medical service may be medically reasonable and necessary under one set of circumstances in California, but not so under the same circumstances in other states (or not amenable to initial judge or jury determination at all in federal courts in Illinois or Iowa). It is fundamentally unfair for Medicare beneficiaries to be subject to different sets of rules based on nothing more than the fact that their claims are being litigated in different states or circuits. See also United States' *Bodimetric* Opp. at 9 ("there is no reason to believe that Congress would have intended to permit adjudicatory decisions made by persons responsible for administering a federal program that is pervasively regulated by federal statutory law to form the basis for personal liability under the varying common law of the States").

Finally, the California Supreme Court's decision may give rise to an irrational distinction between Medicare beneficiaries who choose a fee-for-service option and those who choose managed care, if it is interpreted to mean that only the latter are able to proceed directly to court and seek consequential damages for a benefit denial they view as wrongful. If that occurs, the costs and risks of providing HMO coverage to Medicare beneficiaries will rise relative to the provision of fee-for-service Medicare benefits, a result unsupported by statutory language and contrary to congressional intent and current policy goals. See *supra* at 13 & 14.

The Medicare program provides health care to millions of Americans and constitutes a significant sector of the health care industry. The outcomes described above are dangerous and disruptive to this vitally important program and to Medicare contractors, and are contrary to Congress' expressed will. Indeed, the dissenting California Supreme Court justices rightly concluded that the decision "all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review." App. 39a. The case is therefore of profound national importance, and this Court's review is warranted.

* * * *

A state law or other federal claim that is predicated upon a wrongful denial of Medicare benefits or a violation of other rights under the Medicare Act "aris[es] under" that Act and must be administratively exhausted and then reviewed exclusively in federal court. 42 U.S.C. § 405(h). The immediate and substantial harm inflicted upon an important federal program by the California Supreme Court's contrary ruling amply justifies certiorari review.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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August 1, 2001

APPENDIX A

SUPREME COURT OF CALIFORNIA

No. S082236

BARBARA MCCALL,
Individually and as Trustee, etc.,
Plaintiff and Appellant,
v.

PACIFICARE OF CALIFORNIA, INC., *et al.*,
Defendants and Respondents.

May 3, 2001

WERDEGAR, J.

We granted review in this case, limited to the issue whether state law claims against a health maintenance organization (HMO), arising out of its refusal to provide services under a Medicare-subsidized health plan, fall within the exclusive review provisions of the Medicare Act requiring exhaustion of administrative remedies. (42 U.S.C. § 1395 et seq.) As will appear, some disagreement exists among state and federal courts on this question, which has not yet been addressed by the United States Supreme Court. We conclude the claims made here do not fall within Medicare's exclusive review provisions. Accordingly, we affirm the judgment of the Court of Appeal.

FACTS

On review of the judgment of the Court of Appeal reversing the superior court's orders sustaining defendants' demurrers, we examine the complaint de novo to determine whether it alleges facts sufficient to state a cause of action under any legal theory, such facts being assumed true for this

purpose. (*Santa Monica Beach, Ltd. v. Superior Court* (1999) 19 Cal.4th 952, 957, 81 Cal.Rptr.2d 93, 968 P.2d 993; *Blank v. Kirwan* (1985) 39 Cal.3d 311, 318, 216 Cal.Rptr. 718, 703 P.2d 58.)

George McCall, who suffered from progressive lung disease, was a Medicare beneficiary enrolled in PacifiCare of California, Inc. (PacifiCare), an HMO. His primary care physician was Dr. Lakshmi Shukla; his physician provider group, Greater Newport Physicians, Inc. (GNP). Allegedly, Dr. Shukla, PacifiCare and GNP repeatedly refused to refer Mr. McCall to a specialist for a lung transplant or provide other needed care, and ultimately forced him to disenroll from PacifiCare in order to get on the Medicare list for a transplant. During that time, Mr. McCall's condition worsened.[1]

George McCall and his wife, Barbara (the McCalls), brought suit against Dr. Shukla, PacifiCare and GNP, alleging in their operative first amended complaint eight causes of action for tort damages (negligence, wilful misconduct, four counts of fraud including fraudulent misrepresentation and constructive fraud, and negligent and intentional infliction of emotional distress) and a ninth cause of action for injunctive relief from unfair business practices. The complaint alleged defendants had violated statutory duties they owed plaintiffs, including (A) the duty to provide ready referrals consistent with good professional practice (Health & Saf.Code, § 1367, subd. (d)); (B) the duty to render medical decisions unhindered by fiscal and administrative management (*id.*, § 1367, subd. (g)); (C) the duty to provide for expedited review and to notify Mr. McCall of his right to expedited review from the California Department of Corporations when defendants' decisions involved imminent and serious threat to his health (*id.*, § 1368.01, subd. (b)); (D) the duty to engage

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[1] Mr. McCall died shortly before the Court of Appeal rendered its decision in this case, immediately after undergoing a lung transplant paid for by Medicare.

in sufficient quality assurance activities to ensure that the requirements of California law were met in providing services to Mr. McCall (*id.*, § 1370); (E) the duty not to require Mr. McCall to disenroll except for very limited reasons, such as nonpayment of premiums (*id.*, § 1365, subd. (a)); (F) PacifiCare's duty to retain responsibility for all services, including those that it contracted with others to provide Mr. McCall (42 C.F.R. § 417.401 (1999)); (G) the duty to ensure that required services were available and accessible to Mr. McCall (42 C.F.R. § 417.416 (1999)); (H) the duty to provide written notice of noncoverage, including the reason for noncoverage and Mr. McCall's appeal rights before discharging him from hospital care (42 C.F.R. § 417.440(f) (1999)); (I) the duty not to disenroll Mr. McCall, and not to encourage him to disenroll, from PacifiCare (42 C.F.R. § 417.460(a) (1999)); and (J) the duty to provide grievance procedures for issues that do not involve organizational determinations and Medicare appeal rights (42 C.F.R. §§ 417.600, 417.604, 417.606 (1999)).

GNP and PacifiCare (hereafter defendants)[2] demurred, arguing each of plaintiffs' causes of action arose under the Medicare Act, 42 United States Code section 1395 et seq. and, pursuant to 42 United States Code section 405(g), was therefore subject to judicial review only in federal court, after exhaustion of administrative review procedures. The trial court sustained the demurrers without leave to amend and entered judgment accordingly. The Court of Appeal reversed, and we granted review.

DISCUSSION

The Medicare Act, 42 United States Code section 1395 et seq. (the Act or Medicare), a part of the Social Security Act, established a federally subsidized health insurance program

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[2] GNP and Dr. Shukla also demurred on other, more limited grounds, none of which is before this court.

that is administered by the Secretary of Health and Human Services (the Secretary) through the Health Care Financing Administration (HCFA). Part A of Medicare, 42 United States Code section 1395c et seq., covers the cost of hospitalization and related expenses that are "reasonable and necessary" for the diagnosis or treatment of illness or injury. (42 U.S.C. § 1395y(a)(1)(A).) Part B of Medicare (42 U.S.C. § 1395j et seq.) establishes a voluntary supplementary medical insurance program for Medicare-eligible individuals and certain other persons over age 65, covering specified medical services, devices, and equipment. (See 42 U.S.C. §§ 1395k, 1395*o*.) The Act provides for the delegation of Medicare benefit administration to HMO's, which are authorized, pursuant to contracts with the HCFA, to manage benefit requests by Medicare beneficiaries. (*Wartenberg v. Aetna U.S. Healthcare, Inc.* (E.D.N.Y.1998) 2 F.Supp.2d 273, 276.)

The determination whether an individual is entitled to benefits, and the amount of benefits, is entrusted to the Secretary in accordance with regulations prescribed by him or her. (42 U.S.C. § 1395ff(a).) Judicial review of a claim for benefits is available only after the Secretary has rendered a "'final decision'" on the claim, and only in the manner provided for claims for old age and disability benefits arising under the Social Security Act. (*Heckler v. Ringer* (1984) 466 U.S. 602, 605, 104 S.Ct. 2013, 80 L.Ed.2d 622 (*Ringer*); 42 U.S.C. §§ 405(g), (h), 1395ff(b)(1).)[3] The relevant provisions

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[3] In a case involving a non-HMO, fee-for-service claim, the United States Supreme Court described the administrative appeals process as follows: "[T]he Medicare Act authorizes the Secretary to enter into contracts with fiscal intermediaries providing that the latter will determine whether a particular medical service is covered by Part A, and if so, the amount of the reimbursable expense for that service. 42 U.S.C. § 1395h, 42 CFR § 405.702 (1983). If the intermediary determines that a particular service is not covered under Part A, the claimant can seek reconsideration by the . . . (HCFA) in the Department of Health and Human Services.

of the Social Security Act, 42 United States Code section 405(g) and (h), read together, provide that a final decision by the Secretary on a claim "arising under" Medicare may be reviewed by no person, agency or tribunal except in an action brought in federal district court, and then only after exhausting administrative remedies as described above. (42 U.S.C. §§ 405(h), 1395ii; see 42 U.S.C. §§ 1395ff(b)(1), 1395mm(c)(5)(B).)

The question in this case, then, is whether the McCalls' complaint alleges a claim "arising under" the Medicare Act, even though none of the claims seeks payment or reimbursement of Medicare claims. The seminal decision in this area, *Ringer, supra*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, held that a claim arises under Medicare if (1) "'both the standing and the substantive basis for the presentation'" of the claim is the Medicare Act (*id.* at p. 615, 104 S.Ct. 2013), or (2) the claim is "'inextricably intertwined'" with a claim for Medicare benefits (*id.* at p. 614, 104 S.Ct. 2013). The high court, however, recognized that a claim that is "wholly 'collateral'" to a claim for benefits under the Act is not subject to the administrative process; the

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42 CFR §§ 405.710-405.716 (1983). If denial of the claim is affirmed after reconsideration and if the claim exceeds $100, the claimant is entitled to a hearing before an administrative law judge (ALJ) in the same manner as is provided for claimants under Title II of the Act. 42 U.S.C. § 1395ff(b)(1)(C), (b)(2); 42 CFR § 405.720 (1983). If the claim is again denied, the claimant may seek review in the Appeals Council. 42 CFR §§ 405.701(c), 405.724 (1983) (incorporating 20 CFR § 404.967 (1983)). If the Appeals Council also denies the claim and if the claim exceeds $1,000, only then may the claimant seek judicial review in federal district court of the 'Secretary's final decision.' 42 U.S.C. §§ 1395ff(b)(1)(C), (b)(2)." (*Ringer, supra*, 466 U.S. at pp. 606-607, 104 S.Ct. 2013; see generally 42 C.F.R. § 405.701 et seq. (1999) [describing the Medicare fee-for-service appeals process].) A Medicare beneficiary enrolled in an HMO may challenge the Secretary's final determination in the same manner. (42 U.S.C. § 1395mm(c)(5)(B); see 42 C.F.R. §§ 417.600-417.638 (1999).)

court also suggested exhaustion would be excused if a claimant made a colorable showing that an erroneous denial of benefits would injure him or her in a way that could not be remedied by the later payment of benefits. (*Id.* at p. 618, 104 S.Ct. 2013.)[4]

In *Ringer*, the plaintiffs were four Medicare beneficiaries who suffered from respiratory distress; three had had surgery known as bilateral carotid body resection (BCBR) and were seeking reimbursement of the cost thereof, and one sought to have BCBR surgery but claimed he could not afford it absent Medicare coverage. (*Ringer, supra*, 466 U.S. at pp. 605, 609-610, 104 S.Ct. 2013.) The Secretary had ruled that Medicare did not cover BCBR when performed to relieve respiratory distress because the procedure lacked the general acceptance of the professional medical community and thus was not "reasonable and necessary" within the meaning of Medicare. (*Id.* at p. 607, 104 S.Ct. 2013.) The *Ringer* plaintiffs, none of whom had exhausted their administrative remedies, filed a complaint in federal district court seeking declaratory and injunctive relief. (*Id.* at pp. 610-611, 104 S.Ct. 2013.) The district court dismissed the complaint in its entirety for lack of jurisdiction, concluding the essence of the claim was one of entitlement to benefits for the BCBR procedure and that the plaintiffs therefore were required to exhaust administrative remedies before seeking relief in federal court. (*Id.* at p. 611, 104 S.Ct. 2013.) The Court of Appeals for the Ninth Circuit reversed, concluding exhaustion would be futile and might not fully compensate the plaintiffs for the injuries they asserted. (*Id.* at p. 612.) The Supreme Court reversed.

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[4] The dissent (106 Cal. Rptr.2d pp. 292-293, 21 P.3d 1207-1208) suggests the possible imposition by the Secretary of civil monetary penalties against contracting HMO's for violations of the Medicare Act justifies a conclusion that plaintiffs' state law claims are preempted. The suggestion, however ignores *Ringer*'s focus on the presence or absence of a *remedy for injuries suffered.*

The high court noted that, in *Weinberger v. Salfi* (1975) 422 U.S. 749, 760-761, 95 S.Ct. 2457, 45 L.Ed.2d 522, where the plaintiffs had sought an award of Social Security benefits (a type of claim that, as noted above, is subject to the same administrative exhaustion provisions as those seeking Medicare benefits), it had construed the " 'claim arising under' language quite broadly to include any claims in which 'both the standing and the substantive basis for the presentation' of the claims is the Social Security Act." (*Ringer, supra*, 466 U.S. at p. 615, 104 S.Ct. 2013; see *Weinberger v. Salfi, supra*, at pp. 760-761, 95 S.Ct. 2457 [constitutional challenge to the duration-of-relationship eligibility statute was a "'claim arising under'" the Social Security Act, even though it was also, in another sense, a claim arising under the Constitution].) Any other conclusion, the high court reasoned, would allow claimants substantially to undercut Congress's carefully crafted scheme for administering Medicare. (*Ringer, supra*, at p. 621, 104 S.Ct. 2013.)

Because the Medicare beneficiaries in *Ringer*, at bottom, sought Medicare reimbursement or authorization for a particular surgical procedure, the high court had no difficulty concluding the claim was one in which both the standing and the substantive basis of the claim was the Act, and that the complaint was, thus, one "arising under" Medicare. Perhaps for that reason, the court did not define the phrase "inextricably intertwined," as used in this context, or elaborate on the extent to which a state law claim may be "intertwined" with a Medicare claim before it becomes inextricably so. (See *Ringer, supra*, 466 U.S. at pp. 611, 614-615, 104 S.Ct. 2013.) A closer question than that posed in *Ringer*, however, arises where the complaint seeks, on state tort law grounds, not reimbursement for an assertedly covered procedure, but, rather, damages assertedly flowing from conduct only incidentally related to the wrongful denial of a benefits claim.

Such a situation was present in *Ardary v. Aetna Health Plans of California, Inc.* (9th Cir.1996) 98 F.3d 496, certiorari denied (1997) 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed.2d 174 (*Ardary*), on which the McCalls rely. In *Ardary*, a Medicare beneficiary who lived in a rural area and was enrolled in an HMO suffered a heart attack and was refused airlift transportation to a more sophisticated medical facility than those available nearby. When the beneficiary died, her family sued the HMO and its contractor, Arrowest Physician Association, in state court. They sought compensatory and punitive damages on six state tort law theories: negligence, intentional and/or negligent infliction of emotional distress, intentional and/or negligent misrepresentation, and professional negligence. (*Id.* at pp. 497-498.) The defendants in *Ardary* removed the case to federal court and sought dismissal, arguing all of the plaintiffs' state law causes of action related to the denial of Medicare benefits and, therefore, were preempted by federal law requiring they be addressed through the Medicare administrative appeals process. The Court of Appeals for the Ninth Circuit concluded the complaint did not state any claims in which both the standing and the substantive basis for the presentation of the claims was the Medicare Act; rather, the complaint was predicated on state common law theories. (*Ardary*, at pp. 499-500.) The *Ardary* court also concluded the plaintiffs' state law claims were not "'inextricably intertwined'" with the assertedly wrongful denial of Medicare benefits because the plaintiffs were not seeking to recover benefits, and because the harm the defendants allegedly caused could not be remedied by the payment of benefits. (Id. at p. 500.)[5]

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[5] A number of subsequent decisions have favorably cited and relied on *Ardary*. (E.g., *Plocica v. Nylcare of Texas, Inc.* (N.D.Tex.1999) 43 F.Supp.2d 658, 663 [complaint alleging wrongful death under state law was not preempted by Medicare; case remanded to state court]; *Zamora-*

Quezada v. HealthTexas Medical Group (W.D.Tex.1998) 34 F.Supp.2d 433, 440 [complaint by physicians and Medicare HMO beneficiaries, alleging that HMO's created contractual arrangement that resulted in discrimination against the disabled in violation of the Americans with Disabilities Act, the Rehabilitation Act and various state law theories, did not arise under Medicare; federal district court denied defendants' motion to dismiss for failure to exhaust administrative remedies]; *Wartenberg v. Aetna U. S. Healthcare, Inc., supra*, 2 F.Supp.2d at pp. 277-278 [complaint alleging wrongful death under state law not preempted by Medicare; case remanded to state court]; *Albright v. Kaiser Permanente Medical Group* (N.D.Cal., Aug. 3, 1999, No. C98-0682 MJJ), 1999 WL 605828, *3-*4 [a complaint alleging unfair business practices, violation of the covenant of good faith and fair dealing, and fraud did not arise under Medicare; case remanded to state court]; *Kelly v. Advantage Health, Inc.* (E.D.La., May 11, 1999, Civ. A No. 99-0362), 1999 WL 294796, *4-*5, *7 [a complaint alleging negligence and violation of Louisiana Health Maintenance Organization Act, La.Rev.Stat. § 22:2001 et seq., did not arise under Medicare; case remanded to state court]; *Berman v. Abington Radiology Associates* (E.D.Pa., Aug. 14, 1997, Civ.A. No. 97-3208), 1997 WL 534804, *3 [a complaint alleging professional negligence did not arise under Medicare; case remanded to state court]; see also *Wright v. Combined Ins. Co. of America* (N.D.Miss.1997) 959 F.Supp. 356, 363 [not citing *Ardary*, but concluding fact that disposition of plaintiff's state law claims might require some interpretation of the Medicare Act did not mean such claims arose under the Act; case remanded to state court].)

Other decisions have distinguished *Ardary* without criticizing its reasoning. (*E.g., Jamaica Hospital Nursing Home v. Oxford Health Plans* (S.D.N.Y., Sept. 26, 2000, No. 99 Civ. 9541(AGS)) 2000 WL 1404930, *3 [nursing home's complaint alleging it provided medical treatment to beneficiary and, under its assignment of insurance rights from beneficiary, was entitled to payment from HMO for the cost of the treatment was, at bottom, a claim for reimbursement of Medicare benefits; because nursing home had failed to exhaust administrative remedies, federal district court dismissed complaint for lack of subject matter jurisdiction]; *Helping Hands Professional Home Health Services, Inc. v. Shalala* (S.D.Cal., Aug. 1, 1997, No. 97-1043 IEG(LSG), 1997 WL 778990, *4 [service provider's complaint, alleging that fiscal intermediary failed to comply with regulations governing payments under Medicare system, arose under Medicare; because provider had failed to exhaust administrative remedies, federal district court dismissed complaint for lack of subject matter jurisdiction].)

Defendants suggest that, although the *Ardary* court recited the test articulated in *Ringer, supra*, 466 U.S. at pages 614-615, 104 S.Ct. 2013, it did not address or resolve the potential conflict between an award of state law tort damages proximately resulting from a wrongful denial of Medicare benefits, on the one hand, and the possibility that an exhaustive administrative appeal would determine that Medicare benefits were not *wrongly* denied in the particular case, on the other. Because, as *Ringer* made clear, Congress has vested in the Secretary the exclusive power to administer the Medicare system, defendants contend that any state court damage award that is logically dependent on a finding of wrongful denial of benefits is "'inextricably intertwined'" (*Ringer, supra*, at p. 614, 104 S.Ct. 2013) with a Medicare claim.

Such was the conclusion of the Court of Appeal in *Redmond v. Secure Horizons, Pacificare, Inc.* (1997) 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174 (*Redmond*). In that case, the plaintiff HMO subscriber sued her HMO on various state contract and tort law theories for its initial denial of coverage and subsequent delay in reimbursing her for health care expenses covered under her Medicare-subsidized plan. The superior court dismissed the complaint, ruling it lacked jurisdiction because the plaintiff's causes of action arose under Medicare. The Court of Appeal affirmed. The fact the plaintiff's causes of action were based on her contractual relationship with the HMO did not mean her claims did not arise under Medicare, the court reasoned; indeed, the contract expressly provided that coverage determinations would be based on the Medicare Act and resolved through the multilevel Medicare administrative review process. (*Redmond*, at p. 101, 70 Cal.Rptr.2d 174.) Moreover, the Court of Appeal held, each of the plaintiff's state law causes of action was inextricably intertwined with a claim that she was entitled to the reimbursement she eventually received. (*Id.* at p. 102, 70 Cal.Rptr.2d 174.)

The plaintiff in *Redmond* argued her claim was based, not on her entitlement to benefits, but on the defendant's conduct with respect to her claim for benefits. The Court of Appeal disagreed: "This argument fails because the alleged wrongfulness of defendant's conduct depends on whether plaintiff was entitled to payment of her claim. The fact that defendant ultimately paid her claim does not necessarily establish that plaintiff was *entitled* to such payment." (*Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174.)

Finally, the *Redmond* plaintiff contended her case fell outside the administrative exhaustion requirement because, as recognized in *Ringer, supra*, 466 U.S. at page 618, 104 S.Ct. 2013, and *Ardary, supra*, 98 F.3d at page 500, the initial denial and subsequent delay in paying benefits caused injury that could not be remedied by the later payment of benefits. The Court of Appeal dismissed the contention, concluding the plaintiff could have pressed her claim through the administrative review process. The court opined the administrative process governs not only coverage determinations but also "'any other determination *with respect to* a claim for benefits,'" (*Redmond, supra*, 60 Cal.App.4th at p. 103, 70 Cal.Rptr.2d 174) and observed that the Secretary can order civil money penalties or "'any other remedies authorized by law'" (*ibid.*).[6] *Redmond*, however, cited no authority for the implied proposition that the Secretary is empowered to award damages for violations of state tort law.[7]

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[6] The federal district court in *Albright v. Kaiser Permanente Medical Group, supra*, 1999 WL 605828, *4, observed that "*Redmond* has not been cited as persuasive authority in any subsequent opinions interpreting whether state law claims arise under the Act." A decision not citing *Redmond*, but employing a similar analysis to reach a similar conclusion, is *Wilson v. Chestnut Hill Healthcare* (E.D.Pa., Feb. 22, 2000, Civ. A No. 99-CV-1468), 2000 WL 204368.

[7] *Kelly v. Advantage Health, Inc., supra*, asserts the contrary. "Indeed, the legislative history indicates that the administrative remedies and

The *Redmond* court's rationale—i.e., that the plaintiff's state tort law claims were inextricably intertwined with a Medicare claim because the alleged wrongfulness of the defendant's conduct depended on whether the plaintiff was, in fact, entitled to payment of her claim—has a certain logic. In applying one portion of the *Ringer* analysis, however, the *Redmond* court elided over the other. That is, it failed adequately to explain how the alleged harms suffered by the *Redmond* plaintiff could be remedied through the Medicare administrative review process. If those harms could not be so remedied, then the *Redmond* court's holding hinges on a conclusion that, by establishing an administrative process for Medicare benefit determinations, Congress must have intended to oust state courts of jurisdiction to enforce such of their own tort laws as may be implicated by conduct incidental to benefit determinations. We are directed to no evidence supporting such a conclusion.

We presume that in enacting laws, Congress does not intend to preempt state regulation of the same subject matter unless a contrary intent is made clear. (*Medtronic, Inc. v. Lohr* (1996) 518 U.S. 470, 485, 116 S.Ct. 2240, 135 L.Ed.2d 700; *Cipollone v. Liggett Group, Inc.* (1992) 505 U.S. 504, 516, 112 S.Ct. 2608, 120 L.Ed.2d 407.) The classic example of clear congressional intent to preempt state remedies is

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specific judicial review procedures were established for 'quite minor matters,' such as amount determinations of specific Medicare benefits. See *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 680, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986); *Ardary*, 98 F.3d at 501. The administrative agency in charge of applying the administrative procedure set forth in the Act does not even possess the authority to assess the validity or merit of tortious claims or to grant relief for the types of state law causes of action at issue here. Thus, under the administrative process, plaintiff would most likely be precluded from receiving damages for any of the wrongs that have allegedly been committed against him." (*Kelly v. Advantage Health, Inc., supra*, 1999 WL 294796, at p. *7.)

found in the Employee Retirement Income Security Act of 1974 (ERISA), 29 United States Code section 1001 et seq., governing employee benefit plans, including health insurance. ERISA expressly and broadly preempts state law, providing it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." (29 U.S.C. § 1144(a); see *Ingersoll Rand Co. v. McClendon* (1990) 498 U.S. 133, 139-140, 111 S.Ct. 478, 112 L.Ed.2d 474 [ERISA preempts employee's state law claim of wrongful discharge in order to avoid paying pension benefits]; *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 47- 48, 107 S.Ct. 1549, 95 L.Ed.2d 39 [ERISA preempts state law tort and contract claims against insurer for bad faith denial of claim].)

No intent to displace state tort law remedies was expressed in the Medicare Act as it read at the time relevant to this case. (*Ardary, supra*, 98 F.3d at pp. 501-502.) To the contrary, "[t]he first section of the Medicare Act explicitly states [Congress's] intent to minimize federal intrusion in the area." (*Massachusetts Medical Soc. v. Dukakis* (1st Cir.1987) 815 F.2d 790, 791; *Shands Teaching Hosp. v. Humana Medical* (Fla.Dist.Ct.App.1999) 727 So.2d 341, 344.) Title 42, section 1395 of the United States Code provides: "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." Indeed, the Act specifically requires HMO's and other Medicare providers to be state licensed. (42 U.S.C. §1395mm(b).) By clear implication, therefore, Congress left open a wide field for the operation of state law pertaining to standards for the practice of medicine

and the manner in which medical services are delivered to Medicare beneficiaries.

The conclusion that Congress, in enacting the Medicare Act, did not intend to displace the state tort remedies with which we are here concerned is strengthened by consideration of subsequent amendments to the Act. Shortly before the McCalls filed the initial complaint in this case, the Balanced Budget Act of 1997 (the BBA) became law. (Pub.L. No. 105-33 (Aug. 5, 1997) 111 Stat. 328, codified at 42 U.S.C. § 1395w-21 et seq.) The BBA enacted a new part of Medicare known as "Medicare + Choice" that allows a new range of Medicare managed care options. HMO's contracting with Medicare, such as PacifiCare, automatically became Medicare + Choice plans effective January 1, 1999. (See 42 U.S.C. § 1395mm(k).) The BBA is noteworthy for its addition of an express limited preemption provision to the Medicare Act. By its terms, Medicare now preempts state laws mandating benefits to be covered, mandating inclusion of providers and suppliers, and coverage determinations. (42 U.S.C. § 1395w-26(b)(3).) Pursuant to the related regulations, determinations on issues other than whether a service is covered under a Medicare + Choice contract fall outside the definition of coverage determinations. (42 C.F.R. § 422.402 (1999).) All other types of state laws not inconsistent with Medicare standards are permitted. (*Ibid.*) The preamble to HCFA's request for final comments on the interim final rule implementing the amendments states: "Prior to the BBA, section 1876 of the Act [42 U.S.C. § 1395mm] (governing Medicare risk and cost contracts with HMOs and competitive medical plans) did not contain any specific preemption provisions. However, section 1876 requirements could preempt a State law or standard based on general constitutional Federal preemption principles. . . . Put another way, if Federal law permitted the HMO to do what State law required, there was no preemption. In practice, rarely, if ever, did Federal law preempt State laws affecting

Medicare prepaid plans. For example, Medicare risk plans operating in States with mandated benefit laws were generally required to comply with such State laws. Compliance with the State mandated benefit law was not viewed as interfering with the ability of plans to function as Medicare risk contractors under Federal standards. . . . [¶] . . . [¶] . . . [T]he specific preemption [added by the BBA] does not preempt State remedies for issues other than coverage under the Medicare contract (i.e. tort claims or contract claims under State law are not preempted). The same claim or circumstance that gave rise to a Medicare appeal may have elements that are subject to State remedies that are not superseded. For example, [a Medicare + Choice] organization's denial of care that a beneficiary believes to be covered care is subject to the Medicare appeals process, but under our interpretation of the scope of the specific preemption on coverage decisions, the matter may also be the subject of a tort case under State law if medical malpractice is alleged, or of a state contract law claim if an enrollee alleges that the [Medicare + Choice] organization has obligated itself to provide a particular service under State law without regard to whether it is covered under its [Medicare + Choice] contract." (63 Fed.Reg. 34967, 35012, 35013 (June 26, 1998).) Because, prior to the BBA, Medicare preemption of state law claims was even narrower than the limited preemption enacted by the BBA, these comments strongly imply that state law claims such as those involved in the present case were not preempted under then applicable law.

As the McCalls observe, Medicare regulations provide for administrative review of a limited class of claims (42 C.F.R. § 417.600 et seq. (1999)), not including those pertaining to quality of care, marketing problems and forced disenrollment such as the McCalls have alleged in their complaint. Absent clear indication of congressional intent, we decline to find preemption of claims, founded in California law, that find no remedy under the Medicare administrative process.

We must now turn to the specific causes of action contained in the first amended complaint to determine whether any is inextricably intertwined with a claim for Medicare benefits. Neither the high court in *Ringer, supra*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, nor the Ninth Circuit in *Ardary, supra*, 98 F.3d 496, essayed a definition of this key phrase. The Court of Appeal in *Redmond, supra*, 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174, may be understood to have held that any claim incidental to a coverage determination, whether it seeks payment (or reimbursement) for medical services or tort damages resulting from the manner in which coverage was denied, is inextricably intertwined with a claim for Medicare benefits. (*Id.* at pp. 102-103, 70 Cal.Rptr.2d 174.) Defendants urge us to adopt such a reading of the Act.

We believe *Redmond* painted with too broad a brush in so holding. A Medicare provider may violate state common law or statutory duties owing to beneficiaries, unrelated to its Medicare coverage determinations. The "inextricably intertwined" language in *Ringer* is more correctly read as sweeping within the administrative review process only those claims that, "at bottom," seek reimbursement or payment for medical services, but not a claim *not* seeking such reimbursement or payment, which claim as pleaded incidentally refers to a denial of benefits under the Medicare Act. (See *Ringer, supra*, 466 U.S. at pp. 614-615, 104 S.Ct. 2013.) The latter type of state law based claims by Medicare beneficiaries is not subject to the administrative review process and may be pursued in our state courts. In the language of *Ringer*, at page 618, 104 S.Ct. 2013, such claims are collateral to, not inextricably intertwined with, Medicare benefit claims.

For example, a provider may negligently fail to use ordinary skill and care in treating a beneficiary, or properly to advise the beneficiary concerning his health condition or

appropriate treatment options, whether or not such options are covered by Medicare, thus preventing the beneficiary from seeking such treatment even at his own expense. Or a provider may fail to provide appropriate referrals to specialists, and thus prevent the beneficiary from obtaining appropriate care, again without regard to coverage. The McCalls' first and second causes of action, for negligence and wilful misconduct, respectively, set forth such allegations and enumerate the statutory and regulatory bases of the relevant duties (see *ante*, 106 Cal.Rptr.2d p. 274, 21 P.3d p. 1192), none of which necessarily implicates a coverage determination or falls within the scope of the Medicare administrative review process.

A provider may make misrepresentations regarding the nature or extent of the services it intends to provide, either in its application for HMO licensure to the California Department of Corporations or in its marketing materials disseminated to potential enrollees. If the injury to the enrollee is foreseeable, a *Randi W.* cause of action [8] or a claim of fraud may be stated.[9] The McCalls' third, fourth and

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[8] (See *Randi W. v. Muroc Joint Unified School Dist.* (1997) 14 Cal.4th 1066, 60 Cal.Rptr.2d 263, 929 P.2d 582.)

[9] We note that the recent decision in *Buckman Co. v. Plaintiffs' Leg. Com.* (2001) 531 U.S. 341, 121 S.Ct. 1012, 148 L.Ed.2d 854, concluded that a state law action seeking damages for injuries allegedly caused by Food and Drug Administration (FDA) approved bone screws, predicated on a "fraud-on-the-FDA" theory, was preempted by the Federal Food, Drug, and Cosmetic Act, as amended by the Medical Device Amendments of 1976, 21 United States Code section 301. The high court reasoned that "[p]olicing fraud against federal agencies is hardly 'a field which the States have traditionally occupied,' [citation], such as to warrant a presumption against finding federal pre-emption of a state-law cause of action." (531 U.S. at p. ___, 121 S.Ct. at p. 1017, 148 L.Ed.2d at p. 860.) The court contrasted "situations implicating 'federalism concerns and the historic primacy of state regulation of matters of health and safety,'" where a "presumption against pre-emption obtains." (*Id.* at p. ___, 121 S.Ct. at p. 1017, 148 L.Ed.2d at p. 861, citing *Medtronic, Inc. v. Lohr*,

fifth causes of action allege such claims, none of which necessarily implicates coverage determinations or falls within the scope of the Medicare administrative review process.

A provider may breach the fiduciary duty it owes the enrollee (see *Moore v. Regents of University of California* (1990) 51 Cal.3d 120, 129, 271 Cal.Rptr. 146, 793 P.2d 479), inter alia, by permitting its financial interest detrimentally to affect treatment decisionmaking or failing to disclose such interest. The McCalls' sixth cause of action alleges such a claim, which does not necessarily implicate coverage determinations or fall within the scope of the Medicare administrative review process.

If a defendant's violations of state law duties are sufficiently outrageous, a claim for negligent or intentional infliction of emotional distress may be stated; the McCalls' seventh and eighth causes of action allege such violations, none of which necessarily implicates coverage determinations or falls within the scope of the Medicare administrative review process.

Finally, such violations of statutory duties, none necessarily implicating coverage determinations or falling within the scope of the Medicare administrative review process, may amount to unfair practices as prohibited by Business and Professions Code section 17200; the McCalls' ninth cause of action so alleges.[10]

Because the McCalls may be able to prove the elements of some or all of their causes of action without regard, or only

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supra, 518 U.S. at p. 485, 116 S.Ct. 2240.) To the extent the McCalls' complaint alleges fraud on the HCFA, defendants may, on remand, assert it is preempted under the rule in *Buckman*.

[10] This case does not call upon us to determine the sufficiency of any of the McCalls' allegations to state a cause of action under California law, and we express no opinion on whether the claims ultimately will be proven.

incidentally, to Medicare coverage determinations, because (contrary to the dissent's characterization of the complaint) none of their causes of action seeks, at bottom, payment or reimbursement of a Medicare claim or falls within the Medicare administrative review process, and because the harm they allegedly suffered thus is not remediable within that process, it follows that the Court of Appeal correctly reversed the trial court's orders sustaining defendants' demurrers without leave to amend.[11]

We therefore affirm the judgment of the Court of Appeal and disapprove the decision in *Redmond v. Secure Horizons, Pacificare, Inc., supra*, 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174, to the extent it is inconsistent with this opinion.

GEORGE, C.J., MOSK, J., KENNARD, J., and CHIN, J., concur.

BAXTER, J., dissenting.

The Medicare Act (42 U.S.C. § 1395 et seq.) (hereafter sometimes referred to as Medicare or the Act) is a massive federally insured program that covers health services for the elderly and disabled. Congress has decreed that any enrollee of a Medicare health maintenance organization (HMO) plan who wishes to challenge the HMO's denial of health services under Medicare must do so through Medicare's administrative review process; if that process yields a final decision that is adverse to the enrollee, then judicial review must be sought in federal court. (42 U.S.C. § 1395ff.)

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[11] Defendants' reliance on *Bodimetric Health Services v. Aetna Life & Cas.* (7th Cir.1990) 903 F.2d 480, *Midland Psychiatric Associates, Inc. v. U.S.* (8th Cir.1998) 145 F.3d 1000, and *Marin v. HEW, Health Care Financing* (9th Cir.1985) 769 F.2d 590, is misplaced: those cases are distinguishable from the present one, in that they were actions seeking tort damages for harm allegedly sustained as a result of improper denial of claims, not, as here, claims arising from violations of duties separate from the duty to pay Medicare benefits.

Disregarding that congressional mandate and key United States Supreme Court authority, the majority opinion allows virtually any Medicare HMO plan enrollee to bring suit in state court to challenge an HMO's denial of Medicare benefits. Enrollees may bypass Medicare's exhaustion requirements simply by styling their challenges as claims for tort damages. As a result, questions regarding which medical procedures are or should be covered by Medicare may now be decided outside of Medicare's exclusive review process by California judges and juries on an ad hoc basis.

Congress acted deliberately to ensure uniform administrative and federal accountability for Medicare HMO decisionmaking. Yet today's decision sets the stage for potential conflict between an award of state law tort damages following a determination in a state court that Medicare benefits were wrongly denied, on the one hand, and the possibility that an exhaustive administrative appeal, followed by federal court review, would determine that Medicare benefits were *not wrongly denied* in the particular case and in other comparable cases, on the other. The two cannot be squared; accordingly, I dissent.

I.

The Medicare Act is a part of the Social Security Act that establishes a federally subsidized health insurance program for elderly and certain disabled persons. (42 U.S.C. § 1395 et seq.) In the year 2000, the program provided health insurance coverage for 39 million persons, or one in seven Americans, and paid benefits in the total amount of approximately $217 billion. (The Henry J. Kaiser Family Foundation, Medicare at a Glance (Feb.2001) p. 1.)

To ensure the orderly and efficient functioning of this enormous federal program, Congress has entrusted its administration to the Secretary of Health and Human Services (the Secretary), who manages the program through the Health

Care Financing Administration (HCFA). Pursuant to congressional authorization, the Secretary has established an extensive set of regulations to govern the program. (42 U.S.C. § 1395hh.)

Briefly, the Medicare system works like this. Eligible patients may obtain Medicare benefits in two ways. Where a patient elects to receive health care on a fee-for-service basis, the patient first consults with a physician and receives the recommended health services. The health care provider submits the bill for payment to a Medicare fiscal intermediary, typically a private company that has contracted with the Secretary to act as an adjuster. The intermediary then determines whether the services in question are covered by Medicare and the amount due for the services. (See *Bodimetric Health Services, Inc. v. Aetna Life and Casualty* (7th Cir.1990) 903 F.2d 480, 482 & fn. 3 (*Bodimetric*).) Alternatively, an eligible patient may elect to receive Medicare benefits through enrollment with an HMO that has contracted with the Secretary through HCFA to be reimbursed for services rendered to enrollees. In such situations, the patient receives treatment either from the HMO's own physicians or from physicians who have contracted with the HMO, as in the case of defendant PacifiCare of California, Inc. (PacifiCare), here. When HCFA contracts with an HMO, there is no separate fiscal intermediary and the HMO makes an "organization determination" (an initial determination) whether health services requested on behalf of an enrollee are covered under Medicare and whether they should be furnished, arranged for, or reimbursed. (42 C.F.R. § 417.606 (2000).)

Health services covered under Medicare, whether or not provided through an HMO, are subject to the following important limitation: "Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for

items or services—[¶] . . . which . . . are not *reasonable and necessary* for the diagnosis or treatment of illness or injury. . . ." [1] (42 U.S.C. § 1395y(a)(1)(A), italics added; see *Roen v. Sullivan* (D.Minn.1991) 764 F.Supp. 555, 557.) Thus, if an HMO plan enrollee requests a health service that is not medically reasonable and necessary, the enrollee generally is not entitled to the benefit and the HMO is not obligated to provide for it.

Under the Act, an individual's entitlement to Medicare benefits must be determined in the manner provided for by the Secretary: "The determination of whether an individual is entitled to benefits . . . , and the determination of the amount of benefits . . . , and any other determination with respect to a claim for benefits . . . shall be made by the Secretary in accordance with regulations prescribed by him." (42 U.S.C. § 1395ff(a).) The Secretary is authorized to impose, in addition to "any other remedies authorized by law," civil monetary penalties and to suspend payment to or enrollment of a contracting HMO or fiscal intermediary where, among other things, such an organization "fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual" (42 U.S.C. § 1395mm(i)(6)(A)(i)) or "misrepresents or falsifies information that is furnished—[¶] . . . to the Secretary . . . or—[¶] . . . to an individual" (*id.*, § 1395mm(i)(6)(A)(v)). (See also 42 C.F.R. § 417.500 (2000).)

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[1] Part A of Medicare is a mandatory hospital insurance program covering the cost of hospitalization and related expenses. (42 U.S.C. § 1395c et seq.) Part B establishes a voluntary supplemental medical insurance program covering specified medical services, devices, and equipment. (*Id.*, § 1395j et seq.)

Integral to the Medicare scheme is a thorough administrative review process for an individual "dissatisfied with a determination regarding his or her Medicare benefits." (42 C.F.R. § 417.600(a)(1) (2000); see *id.*, § 417.600 et seq.; 42 U.S.C. § 1395ff(b)(1).) Judicial review of claims arising under the Medicare Act is available only in federal court, and only then if the amount in controversy is at least $1000 and the Secretary has rendered a "final decision" on the claim, in the same manner as is provided for old age and disability claims arising under Title II of the Social Security Act. (42 U.S.C. §§ 405(g), (h), 1395ff(b)(1)(C).)

Pursuant to rulemaking authority granted by Congress, the Secretary has provided that a final decision is rendered on a Medicare claim only after the individual claimant has presented the claim through all designated levels of administrative review, including review by HCFA or its agent, an administrative law judge (ALJ), and the departmental appeals board. (*Heckler v. Ringer* (1984) 466 U.S. 602, 606-607, 104 S.Ct. 2013, 80 L.Ed.2d 622 (*Ringer*); 42 C.F.R. § 417.600 et seq.) Portions of the administrative review process must be expedited where the usual time frames "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." (42 C.F.R. §§ 417.609(b), 417.617(b) (2000).) As the legislative history explains, "[i]t is intended that the remedies provided by these review procedures shall be *exclusive*." (Sen.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1965 U.S.Code Cong. & Admin. News pp.1943, 1995, italics added.)

The broad scope of Medicare's exclusive review process was emphasized in *Ringer, supra*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, the United States Supreme Court's seminal decision on the issue. In *Ringer*, four individual Medicare beneficiaries filed a federal court action for declaratory and injunctive relief that challenged the

Secretary's formal policy of denying Medicare coverage for a surgical procedure known as bilateral carotid body resection (BCBR). Three of the plaintiffs had undergone BCBR surgery but were denied reimbursement for the surgery by fiscal intermediaries. Although some of the levels of the administrative review process had been completed, none of the three had received a final decision on their benefit claims from the Secretary. (466 U.S. at pp. 609-610, 104 S.Ct. 2013.) The fourth plaintiff, who did not have the surgery because he could not afford it, had not submitted a claim for reimbursement. (*Id.* at p. 610, 104 S.Ct. 2013.) The four plaintiffs contended in federal court that the Secretary had a constitutional and statutory obligation to provide payment for BCBR surgery and that the Secretary's formal ruling refusing to find the BCBR surgery "reasonable and necessary" under the Act was unlawful. (*Ringer, supra*, 466 U.S. at pp. 610-611, 104 S.Ct. 2013.)

In *Ringer*, the Supreme Court considered whether the plaintiffs, who were not seeking an award of benefits, could bring an action directly in federal court without pursuing administrative remedies. In analyzing the issue, the court initially observed that judicial review is unavailable for "'claim[s] arising under'" the Medicare Act, and that claims arise under Medicare if they are "'inextricably intertwined'" with claims for Medicare benefits. (*Ringer, supra*, 466 U.S. at pp. 614-615, 104 S.Ct. 2013.) Noting that the phrase "claim arising under" had been judicially construed "quite broadly," the high court concluded that a claim arises under Medicare where "'both the standing and the substantive basis for the presentation'" of the claim is the Medicare Act. (*Ringer, supra*, 466 U.S. at p. 615, 104 S.Ct. 2013.)

Turning to the facts of the case, the Supreme Court first noted that the Secretary's formal ruling was inapplicable to the claims of the first three plaintiffs due to timing. But their claims, which did not seek an actual award of benefits,

nonetheless "[arose] under" the Medicare Act because the Act furnished both the standing and the substantive basis for their claims. (*Ringer, supra*, 466 U.S. at p. 615, 104 S.Ct. 2013.) As for the fourth plaintiff, whose claim was in fact subject to the Secretary's ruling, the Supreme Court viewed him as clearly seeking "to establish a right to future payments should he ultimately decide to proceed with BCBR surgery." (*Id.* at p. 621, 104 S.Ct. 2013.) That the fourth plaintiff was not seeking the immediate payment of benefits was of no importance; his claim " must be construed as a 'claim arising under' the Medicare Act," the court reasoned, "because any other construction would allow claimants substantially to undercut Congress' carefully crafted scheme for administering the Medicare Act. [¶] If we allow claimants . . . to challenge in federal court the Secretary's determination . . . that BCBR surgery is not a covered service, we would be inviting them to bypass the exhaustion requirements of the Medicare Act by simply bringing declaratory judgment actions in federal court before they undergo the medical procedure in question." (*Ibid.*) As part of its analysis, the court found that the administrative review process provided an adequate remedy for challenging both the Secretary's decision that a particular medical service was not reasonable and necessary, and the means by which the Secretary implemented such a decision. (*Id.* at p. 617, 104 S.Ct. 2013.)

In holding that a claim may arise under Medicare while also arising under some other law (i.e., the federal Constitution), the *Ringer* decision looked to *Weinberger v. Salfi* (1975) 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (*Salfi*), for guidance. (*Ringer, supra*, 466 U.S. at p. 615, 104 S.Ct. 2013.) In *Salfi*, a claimant who had been denied Social Security benefits based on "duration-of-relationship" requirements of the Social Security Act filed an action in federal court on behalf of herself, and others similarly situated, challenging the constitutionality of the statutory require-

ments.[2] In response to the claimant's argument that the action arose under the Constitution and not under the Social Security Act, the high court stated: "It would, of course, be fruitless to contend that appellees' claim is one which does not arise under the Constitution, since their constitutional arguments are critical to their complaint. But it is just as fruitless to argue that this action does not also arise under the Social Security Act. For not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions." (*Salfi, supra*, 422 U.S. at pp. 760-761, 95 S.Ct. 2457.) The Supreme Court ultimately concluded in *Salfi* that compliance with the administrative review process was required, even though the claims had a constitutional basis and even though the Secretary had no power to affect an unconstitutional denial of benefits. (*Salfi, supra*, 422 U.S. at p. 764, 422 U.S. 749.)

Taken together, *Ringer* and *Salfi* make clear that claims challenging an HMO's denial of reasonable and necessary health services covered by Medicare must undergo an administrative review for a final decision prior to any judicial review to ensure Medicare's efficient and orderly functioning. As the Supreme Court emphasized in both decisions, "the purpose of the exhaustion requirement is to prevent 'premature interference with agency processes' and to give the agency a chance 'to compile a record which is adequate for judicial review.'" (*Ringer, supra*, 466 U.S. at p. 619, fn. 12, 104 S.Ct. 2013, quoting *Salfi, supra*, 422 U.S. at p. 765, 95 S.Ct. 2457.) That purpose is frustrated substantially when HMO plan enrollees are permitted to bypass the

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[2] Claims seeking payment of ordinary Social Security benefits are subject to the same administrative exhaustion provisions as those seeking Medicare benefits. (Maj. opn., *ante*, 106 Cal.Rptr.2d at pp. 276-277, 21 P.3d at pp. 1194-1195.)

administrative process. As one court aptly summarized, "[t]he lack of a developed record means that plaintiffs in effect call upon the court to play doctor in their cases. The prescribed HMO and agency decisionmaking procedures were designed to avoid that problem." (*Roen v. Sullivan, supra*, 764 F.Supp. at pp. 560-561.)

In California, *Ringer*'s analysis was followed in *Redmond v. Secure Horizons, PacifiCare, Inc.* (1997) 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174 (*Redmond*). In that case, a Medicare HMO plan enrollee underwent a "life-saving" surgery after the HMO initially denied coverage. The enrollee subsequently requested reimbursement for the surgery and the HMO ultimately acquiesced. The enrollee then sued the HMO in state court for breach of contract, breach of the implied covenant of good faith and fair dealing, and negligent and intentional infliction of emotional distress. The HMO demurred, contending that the tort and contract causes of action were inextricably intertwined with the denial of Medicare benefits and were therefore subject to Medicare's administrative procedures.

On review, the Court of Appeal ruled in favor of the HMO: "[W]hile plaintiff's causes of action are not actually a claim for benefits, since she has already obtained reimbursement of her medical expenses, her causes of action *are* 'inextricably intertwined' with a claim that she was entitled to the reimbursement she received. Plaintiff argues that her complaint was not based on her entitlement to benefits but on defendant's 'conduct' with respect to her claim for benefits. This argument fails because the alleged wrongfulness of defendant's conduct depends on whether plaintiff was entitled to payment of her claim." (*Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174; accord, *Wilson v. Chestnut Hill Healthcare* (E.D.Pa., Feb. 22, 2000, No. Civ. A 99-CV-1468), 2000 WL 204368, *4 ["courts must discount any 'creative pleading' which may transform Medicare disputes

into mere state law claims, and painstakingly determine whether such claims are ultimately Medicare disputes"].)

Additionally, federal decisions arising in analogous contexts have followed *Ringer* in foreclosing state law claims by health care providers pertaining to the withholding of Medicare benefit reimbursements.[3] For example, in *Bodimetric, supra*, 903 F.2d 480, a provider filed suit against a Medicare fiscal intermediary, alleging state law claims for fraud and for wrongful misconduct in the processing of its reimbursement claims. Although the action sought recovery of tort damages, not benefit reimbursements, the Seventh Circuit Court of Appeals concluded that the plaintiff could not avoid the Medicare Act's review process "simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits." (903 F.2d at p. 487.) While recognizing that the federal administrative process might not afford the provider all the relief it sought pursuant to its state law claims, the appeals court nonetheless emphasized that "Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process." (*Id.* at p. 486, fn. 5;

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[3] The United States Supreme Court subsequently invoked *Ringer* in a decision holding that damage claims arising from decisions concerning payment of ordinary Social Security benefits are foreclosed by the Secretary's exclusive administrative jurisdiction over such decisions. In *Schweiker v. Chilicky* (1988) 487 U.S. 412, 108 S.Ct. 2460, 101 L.Ed.2d 370, claimants whose Social Security disability benefits were improperly terminated during disability reviews but were later restored, sued federal and state program administrators for alleged violations of their Fifth Amendment right to due process, and sought recovery of damages for emotional distress and for loss of food, shelter, and other necessities proximately caused by the denial of benefits without due process. In that case, the high court determined that since the harm resulting from the alleged constitutional violation was inseparable from that resulting from the denial of benefits, both claims were remediable, if at all, only through the federal administrative review process. (487 U.S. at pp. 428-429, 108 S.Ct. 2460.)

see also *Marin v. HEW, Healthcare Financing Agency* (9th Cir.1985) 769 F.2d 590.)

Similarly, in *Midland Psychiatric Associates, Inc. v. United States* (8th Cir.1998) 145 F.3d 1000 (*Midland*), a health care provider sued a Medicare fiscal intermediary for tortiously interfering with its contracts with hospitals by denying the hospitals' payment claims for services rendered by the provider to Medicare beneficiaries. In affirming dismissal of the provider's action, the Eighth Circuit Court of Appeals reasoned that the intermediary could not be held liable for tortious interference if it had a right to deny the hospitals' payment claims and that hearing the tortious interference claim would mean reviewing the merits of the intermediary's Medicare claims decisions. (145 F.3d at pp. 1002, 1004.) Relying on *Ringer* and *Salfi*, the Eighth Circuit concluded that the tortious interference claim arose under the Medicare Act and was therefore subject to the exclusive federal administrative review procedures, even though, as pleaded, the claim also arose under state law.[4] (145 F.3d at p. 1004;

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[4] In a footnote, the majority expresses awareness of *Bodimetric, supra*, 903 F.2d 480, *Midland, supra*, 145 F.3d 1000, and *Marin v. HEW, Healthcare Financing Agency, supra*, 769 F.2d 590. (Maj. opn., *ante*, 106 Cal. Rptr.2d at p. 283, fn. 11, 21 P.3d at p. 1200, fn. 11.) The majority does not dispute those courts' conclusions that claims "arising under" the Medicare Act, as that phrase was defined in *Ringer, supra*, 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, may encompass state law claims seeking tort damages for harm allegedly sustained as a result of improper denial of claims. (Maj. opn., *ante*, at p. 283, fn. 11, 21 P.3d at p. 1200, fn. 11.) Rather the majority attempts to distinguish the instant case on the basis that it involves "claims arising from violations of duties separate from the duty to pay Medicare benefits." (*Ibid.*) Contrary to the majority's suggestion, and as I explain in part II, *post*, plaintiffs here similarly seek tort damages arising from the alleged improper denial of a benefit, i.e., a lung transplant, to which plaintiffs claim entitlement under Medicare. Although the complaint also alleges violations of "duties" that purport to extend beyond PacifiCare's alleged duty to pay Medicare benefits, the harm supposedly resulting from those violations appears inseparable from

see also *Jamaica Hospital Nursing Home v. Oxford Health Plans* (S.D.N.Y., Sept. 26, 2000, No. 99 Civ. 9541(AGS)) 2000 WL 1404930 [where nursing home alleged that an assignment of insurance rights from a treated patient entitled it to payment from an HMO for the cost of treatment, claim arose under the Medicare Act even though it was presented as a contract claim].)

II.

Under the foregoing authorities, it is evident that what plaintiffs have asserted in this action are "claims arising under" the Medicare Act. Specifically, plaintiffs allege that: (1) PacifiCare breached its duty to comply with state and Medicare regulations governing the provision of health care services and failed to secure for plaintiff George McCall "reasonably necessary" health care services to which he was entitled (negligence, willful misconduct, unfair business practices); (2) PacifiCare misrepresented to government officials and to its own enrollees that it would comport with California Health and Safety Code provisions and with Medicare regulations, yet failed to do so after having secured HMO licensure through the state and an HMO contract through HCFA, and after having induced enrollment by individuals entitled to Medicare benefits (fraud, constructive fraud, unfair business practices); and (3) PacifiCare wrongfully denied plaintiff George McCall the level of health services to which he was entitled under both state law and Medicare by refusing surgical intervention to save his life (a lung transplant) and instead providing a much less expensive course of treatment (intentional and negligent infliction of emotional distress, unfair business practices).

At bottom, plaintiffs challenge PacifiCare's failure to furnish or arrange for "reasonable and necessary" health services covered by Medicare. (42 U.S.C. § 1395y(a)(1)(A).)

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the harm resulting from PacifiCare's denial of the lung transplant. (See pt. II, *post*.)

Critically, plaintiffs' ability to prevail on their state law causes of action inevitably turns upon a determination that plaintiff George McCall was entitled to a Medicare benefit, i.e., a lung transplant, and that PacifiCare had no right to deny such benefit because it was reasonable and necessary for treatment of his condition. (See *Ringer, supra*, 466 U.S. at pp. 610-611, 104 S.Ct. 2013; *Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174.) The consequential damages sought by plaintiffs also are dependent upon such a determination. That being the case, plaintiffs' claims are "inextricably intertwined" with a Medicare benefits determination and are subject to Medicare's administrative review process.

As *Ringer* instructs, it matters not that plaintiffs carefully avoid any formal claim for reimbursement of sums they expended to obtain the services otherwise covered under Medicare. (*Ringer, supra*, 466 U.S. at p. 621, 104 S.Ct. 2013.) Nor does it make a difference that plaintiffs' claims are based in part on state law, for it is the Medicare Act that furnishes both the standing and the substantive basis for the presentation of their state law contentions. (See *id.* at p. 620, 104 S.Ct. 2013; *Salfi, supra*, 422 U.S. at pp. 760-761, 95 S.Ct. 2457.) Distilled to their essence, the state law causes of action necessarily rely upon plaintiff George McCall's status as an individual entitled to Medicare benefits and upon the Medicare Act itself to define the benefits and health services to which he was legally entitled but wrongly denied. Consequently, such claims do not, as the majority suggests, only "incidentally" refer to a denial of benefits under Medicare. (See maj. opn., *ante*, 106 Cal.Rptr.2d at p. 282, 21 P.3d at p. 1199.)

The Supreme Court, I note, has suggested that an exception to exhaustion may arise when a claim is "wholly 'collateral' to [a] claim for benefits," but that such exception will not apply where there is "no colorable claim that an erroneous

denial of . . . benefits in the early stages of the administrative process will injure [the claimant] in a way that cannot be remedied by the later payment of benefits." (*Ringer, supra*, 466 U.S. at p. 618, 104 S.Ct. 2013.) As discussed, however, plaintiffs' state law claims are not wholly collateral to a claim for benefits because, at bottom, they ultimately derive from the contention that plaintiff George McCall was entitled to a lung transplant and other reasonable and necessary medical services denied him by PacifiCare. Moreover, nothing in the record (limited as it may be) suggests plaintiffs could not have overcome PacifiCare's denial of such services through the administrative process if in fact Medicare coverage existed. Indeed, had George McCall initially elected to receive health care on a fee-for-service basis and consulted a physician of his choice for purposes of receiving a lung transplant, and had he been denied reimbursement for the physician's services by a Medicare fiscal intermediary, there would be no question that he would have been required to seek reconsideration of the denial through Medicare's administrative review process. The fact that a Medicare HMO denied his request for a transplant in a managed care setting should make no difference in the legal analysis.

At oral argument on this matter, counsel for plaintiffs could not and did not dispute that the claims concerning PacifiCare's alleged wrongful refusal to arrange for a lung transplant would necessitate a determination whether the transplant was a reasonable and necessary medical treatment to which plaintiff George McCall was entitled under Medicare. Counsel instead argued, and the majority evidently agrees, that no benefit determination would be involved in deciding whether PacifiCare fraudulently induced plaintiff to enroll in PacifiCare, whether PacifiCare wrongfully withheld information regarding treatment options, and whether PacifiCare wrongfully forced plaintiff to disenroll from PacifiCare.

That argument fails to convince. Essentially all of plaintiffs' claims are predicated on the central theory that PacifiCare, as a Medicare HMO, was required to comply with all Medicare rules and regulations, that reasonable and necessary health services covered by Medicare would not be denied, and that all available Medicare treatment options would be discussed and provided. As a result of PacifiCare's alleged misconduct, plaintiff George McCall enrolled in PacifiCare and allegedly was harmed thereby. Moreover, to the extent plaintiffs allege that PacifiCare made fraudulent misrepresentations to Medicare in order to obtain a Medicare HMO contract and to induce enrollment, such claims are, as plaintiffs apparently recognize, barred under the reasoning of *Buckman Co. v. Plaintiffs Legal Committee* (2001), 531 U.S. 341[, 121 S.Ct. 1012] (finding similar fraud claims preempted by the Federal Food, Drug, and Cosmetic Act, as amended by the Medical Device Amendments of 1976). As for the disenrollment claim, plaintiff George McCall allegedly had to disenroll in order to get the lung transplant he sought. Since the harm resulting from all of PacifiCare's alleged misconduct is inseparable from the harm resulting from its denial of the lung transplant, there appears no basis for finding any of the claims exempt from the administrative review process.

In purporting to analyze plaintiffs' complaint, the majority suggests that malpractice may be committed under state law based on a provider's failure to properly advise of treatment options or its failure to provide appropriate referrals to specialists, whether or not such options or referrals were covered by Medicare, and that malpractice as such may prevent a beneficiary from seeking noncovered services at his own expense. (Maj. opn., *ante*, 106 Cal.Rptr.2d at p. 282, 21 P.3d at p. 1199.) This sort of malpractice claim, the majority asserts, would not implicate a coverage determination or fall within the scope of the Medicare review process.

Even assuming the majority states the law correctly in the abstract, the complaint here lacks such a claim. The allegations make no specific reference to any "noncovered" medical treatment about which plaintiff George McCall should have been advised. Nor do they suggest that plaintiff would have undergone a particular noncovered treatment at his own expense but for PacifiCare's alleged misconduct, or that any harm flowed from his ignorance of noncovered treatments. Rather, the crux of the complaint is that plaintiff was harmed by PacifiCare's failure to secure the lung transplant and other reasonable and necessary medical treatment to which he was entitled under Medicare.

To support its contrary conclusion, the majority invokes the Ninth Circuit Court of Appeals' decision in *Ardary v. Aetna Health Plans of California, Inc.* (9th Cir.1996) 98 F.3d 496 (*Ardary*). In *Ardary*, the heirs of a deceased Medicare beneficiary brought state law claims for wrongful death against a private Medicare provider seeking compensatory and punitive damages on the basis that the provider improperly denied medical services (an emergency airlift transfer) and misrepresented its managed care plan to the beneficiary. The provider removed the action to federal court, arguing, among other things, that relief was limited to federal administrative remedies under *Ringer*. The Ninth Circuit disagreed.

Notably, the Ninth Circuit acknowledged that the heirs' state law claims were all predicated on the provider's failure to authorize the emergency airlift transfer. (*Ardary, supra*, 98 F.3d at p. 498.) Yet the court determined their complaint did not arise under the Medicare Act because it did not "'include any claims in which "both the standing and the substantive basis for the presentation" of the claims' is the Act." (*Ardary*, at p. 499.) In its view, standing for the heirs' claims was provided by state common law (e.g., negligence, infliction of emotional distress, misrepresentation, and professional negligence), not the Act. (*Id.* at pp. 499-500.) The court also

concluded the claims were not "inextricably intertwined" with a benefits claim because the heirs were not seeking to recover benefits. (*Id.* at p. 500.) Finally, the court emphasized the inappropriateness of relegating the wrongful death claims to the administrative process because the injury complained of—the beneficiary's death—could not be remedied by the retroactive authorization or payment of the airlift transfer. (*Ibid.*)

Ardary is analytically flawed and cannot support the majority's disregard of the principles articulated by the Supreme Court in *Ringer* and *Salfi*. Contrary to *Ardary*'s reasoning, those decisions affirm that claims may arise under the Medicare Act and be subject to its administrative review process, *even though the claims also arise under some other law*. Thus, even where claims have a state law basis, as exemplified in *Ardary* and in the instant case, they also arise under the Medicare Act where, at bottom, they challenge the correctness of the defendant's denial of health services covered by Medicare. (See *Ringer, supra*, 466 U.S. at p. 615, 104 S.Ct. 2013; *Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174; *Wilson v. Chestnut Hill Healthcare, supra*, 2000 WL 204368, *4; see also *Salfi, supra*, 422 U.S. at pp. 760-761, 95 S.Ct. 2457; *Midland, supra*, 145 F.3d 1000; *Bodimetric, supra*, 903 F.2d 480.) Moreover, the high court firmly rejected the notion that the absence of a formal request for payment of benefits is controlling. (*Ringer, supra*, 466 U.S. at p. 621, 104 S.Ct. 2013.) In any event, the result in *Ardary* was largely influenced by the fact that it was a wrongful death action brought by the heirs of a Medicare beneficiary. (*Ardary, supra*, 98 F.3d at p. 500.) Here, of course, the action was brought by the Medicare beneficiary himself and contains no wrongful death component.

The majority also supports its holding with the observation that the Secretary has no authority to assess the validity or merit of plaintiffs' tort claims or to grant relief for such claims. (Maj. opn., *ante*, 106 Cal.Rptr.2d at p. 279, fn. 7, 21

P.3d at pp. 1196-1197, fn. 7, citing *Kelly v. Advantage Health, Inc.* (E.D.La., May 11, 1999, No. Civ. A 99-0362), 1999 WL 294796.) The Secretary, however, is authorized to impose civil monetary penalties and to suspend payment to or enrollment of a contracting HMO if the HMO "fails substantially to provide medically necessary items and services that are required" to be provided to an individual covered under the contract, where "the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual." (42 U.S.C. § 1395mm(i)(6)(A); see also 42 C.F.R. § 417.500.) The Secretary may also impose such penalties if the HMO "misrepresents or falsifies information that is furnished" to the Secretary or to an individual. (*Ibid.*) Accordingly, it appears the Secretary has been amply armed by Congress to address the type of wrongdoing alleged here.

More to the point, Congress has determined that questions regarding a claimant's entitlement to benefits under the Medicare Act must be decided through Medicare's administrative process to ensure the efficient and even administration of the federally insured program. An individual who is "dissatisfied with [an HMO's] determination regarding his or her Medicare benefits" (42 C.F.R. § 417.600(a)) should not be permitted "to undercut Congress's carefully crafted scheme for administering the Medicare Act" (*Ringer, supra*, 466 U.S. at p. 621, 104 S.Ct. 2013) by making state law contentions that necessitate a state court's review of an HMO's decision to deny benefits covered by Medicare. Where, as here, such contentions are central to a plaintiff's claims for recovery, they remain properly subject to the Act's mandatory administrative process where they may receive a thorough and expedited review. (See *Ringer, supra*, 466 U.S. at p. 619 & fn. 12, 104 S.Ct. 2013; see also *Salfi, supra*, 422 U.S. at p. 765, 95 S.Ct. 2457; *Redmond, supra*, 60 Cal.App.4th at p. 102, 70 Cal.Rptr.2d 174; *Wilson v. Chestnut Hill Healthcare, supra*, 2000 WL 204368, *3, *6.)

The majority also justifies its decision by invoking the general presumption that Congress, in enacting laws, does not intend to preempt state regulation of the same subject matter unless a contrary intent appears, and by relying on title 42, section 1395 of the United States Code,[5] and on the Medicare Act's requirement that HMO's and other Medicare providers be state licensed (42 U.S.C. § 1395mm(b)). (Maj. opn., *ante*, 106 Cal.Rptr.2d at pp. 280-281, 21 P.3d at pp. 1197-1198.)

It is inconceivable that Congress did not intend to oust state courts of jurisdiction to review the merits of an HMO's denial of Medicare benefits. Not only are the provisions of the Act crystal clear on the point (42 U.S.C. §§1395ff(a), (b)(1), 405(g), (h)), but the legislative history expressly indicates that the remedies provided by the administrative review procedures are intended to be *exclusive*. (Sen.Rep. No. 404, 89th Cong., 1st Sess., *supra*, reprinted in 1965 U.S.Code Cong. & Admin. News pp. 1943, 1995.) The legislative declaration codified at title 42, section 1395 of the United States Code (*ante*, fn. 5) and the state license requirement (42 U.S.C. § 1395mm(b)) offer no support for a contrary inference.

Nor is the majority's holding supported by the Balanced Budget Act of 1997 (the BBA), which added a provision to the Medicare Act expressly preempting state standards relating to benefit requirements, coverage determinations, and requirements relating to the inclusion or treatment of

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[5] That section provides: "Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." (42 U.S.C. § 1395.)

providers. (42 U.S.C. § 1395w-21 et seq.) As the HCFA comments quoted by the majority explain (maj. opn., *ante*, 106 Cal.Rptr.2d at pp. 280-281, 21 P.3d at pp. 1197-1198), even though the Medicare Act did not previously contain an express preemption clause, preemption of state laws and standards was proper "based on general constitutional Federal preemption principles." (63 Fed.Reg. 35012 (June 26, 1998).) The quoted comments also clarify the following: that while a claim regarding a Medicare + Choice[6] organization's "denial of care that a beneficiary believes to be covered care is subject to the Medicare appeals process," "the matter may also be the subject of a tort case under State law if medical malpractice is alleged, or of a state contract law claim if an enrollee alleges that the [Medicare + Choice] organization has obligated itself to provide a particular service under State law without regard to whether it is covered under its [Medicare + Choice] contract." (63 Fed.Reg., *supra*, p. 35013.)

Contrary to the majority's assertion, HCFA's comments do not "strongly imply that state law claims such as those involved in the present case were not preempted under then applicable law." (Maj. opn., *ante*, 106 Cal.Rptr.2d at p. 281, 21 P.3d at p. 1198.) If anything, both the comments and the BBA itself settle any doubt regarding Medicare's preemptive scope over claims that essentially rely on state standards and requirements to establish coverage of benefits. Indeed, as HCFA elucidates, "[s]tate laws requiring, for example, a second opinion from non-contracted physicians" would be superseded by the BBA preemptions "because these requirements in essence mandate the 'benefit' of access to a particular provider's services even where the services of that provider would not otherwise be a covered benefit." (63

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[6] HMO's contracting with Medicare, such as PacifiCare here, automatically became Medicare + Choice plans effective January 1, 1999. (See 42 U.S.C. § 1395mm(k).)

Fed.Reg., *supra*, p. 35013.) Although HCFA further explains that preemption does not extend to all medical malpractice and contract claims, that has always been the case where the claims were not inextricably intertwined with a benefits determination. As discussed, however, the claims asserted here do not fall within those long acknowledged categories of exempted claims.

III.

The Medicare Act represents a "carefully crafted scheme" for administering a massive federally insured program (*Ringer, supra*, 466 U.S. at p. 621, 104 S.Ct. 2013). Central to that scheme is Congress's determination that administrative remedies, followed by federal court review if necessary, are appropriate to fully and consistently address the claims of those who seek to challenge an HMO's benefits decision, and that administrative sanctions are appropriate to address certain misconduct by errant HMO's. While the system may not afford the range of relief available under state law, it is designed to provide that coverage decisions are reviewed in a thorough and expeditious manner by HCFA or its agent, and by ALJ's and departmental review boards that have special expertise in such matters. It is not the prerogative of this court to second-guess the measured tradeoffs enacted by Congress.

Today's decision all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review. I cannot, and will not, join in its undoing.

BROWN, J., concurs

APPENDIX B

COURT OF APPEAL, FOURTH DISTRICT
Division 3

No. G024030.

GEORGE MCCALL, *et al.*,
Plaintiffs and Appellants,

v.

PACIFICARE OF CALIFORNIA, INC., *et al.*,
Defendants and Respondents.

Aug. 17, 1999

Certified for Partial Publication.*
Review Granted Dec. 1, 1999.

OPINION

BEDSWORTH, J.

This is an action for negligence, intentional and negligent infliction of emotional distress, unfair business practices and fraud, brought by George and Barbara McCall against George's health maintenance organization, Pacificare of California, Inc., its physician provider group, Greater Newport Physicians, Inc. (GNP), and George's primary care physician, Dr. Lakshmi Shukla.

The McCalls appeal from a judgment sustaining a demurrer without leave to amend, arguing the trial judge wrongly found all their claims arose under the Medicare Act, 42 United

* Pursuant to California Rules of Court, rule 976(b) and 976.1, this opinion is certified for publication with the exception of part III.

States Code section 1395 et seq., which authorizes judicial review only in the federal district courts after exhaustion of administrative remedies. They also contend the judge misread Health and Safety Code section 1371.25 when he ruled a physician provider group is not vicariously liable for the conduct of one of its members. We conclude the claims are not within the federal statute and vicarious liability exists. The emotional distress cause of action was demurrable on other grounds, but leave to amend should have been granted.

At the time George McCall (McCall) enrolled in Pacificare, he was suffering from progressive lung disease. The gravamen of his complaint is that, to save money, Pacificare, GNP and Shukla, repeatedly refused to refer him to a specialist for a lung transplant, or provide other needed care, and ultimately forced him to leave the plan to get on the list for a transplant. During that time his condition worsened, and he is now unable to walk more than a few feet or stand for more than a few minutes without assistance. He needs oxygen to breathe and requires a ventilator at night.

McCall alleges Pacificare, GNP and Shukla were negligent in failing to provide care, as a result of which his condition worsened, he incurred additional medical expenses which will continue. He alleges their conduct was willful and warrants punitive damages. There is a cause of action for intentional infliction of emotional distress, and one for unfair business practices in violation of Business and Professions Code section 17200.

McCall alleges fraud in four separate causes of action. He claims: (1) Pacificare made misrepresentations in state and federal applications to operate as a health maintenance organization (HMO), which created a foreseeable risk of harm to him as an enrollee; (2) Pacificare made misrepresentations to him in its marketing materials; (3) GNP made misrepresentations to induce Pacificare to select it as a provider, creating a foreseeable risk of harm to him as an

enrollee; and (4) Pacificare, GNP and Shukla concealed from him their failure to adequately insulate medical decisions from financial ones, which caused them to deny him care for their own financial gain. Barbara McCall alleges a single cause of action for negligent infliction of emotional distress by Pacificare and GNP, asserting they knew or should have known their failure to provide a lung transplant would cause her severe emotional distress as she watched her husband suffering while his health failed.

The trial judge determined all causes of action arose under the Medicare Act, relying on *Redmond v. Secure Horizons, Pacificare, Inc.* (1997) 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174, and further ruled GNP was not vicariously liable for Shukla's conduct. Judgment was entered dismissing the complaint against Pacificare and GNP.[1]

The McCalls argue their tort claims do not arise under the Medicare Act and were properly brought in state court, while Pacificare and GNP argue all are Medicare claims cognizable only in federal court. We conclude the complaint falls somewhere in between. Since the Medicare and non-Medicare claims are interwoven throughout the various causes of action, the demurrer was proper but the McCalls should have been given leave to amend.

I

The Medicare Act, 42 United States Code section 1395 et seq., is a part of the Social Security Act that creates a federally subsidized health insurance program administered by the Secretary of Health and Human Services (Secretary). Part A provides insurance for the cost of hospital and related post-hospital expenses, but reimbursement is authorized only for services found reasonable and necessary for the diagnosis or treatment of illness or injury. (42 U.S.C., § 1395y(a)(1).)

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[1] Apparently Shukla did not file a demurrer, and the judgment dismissed the action against Pacificare and GNP but not Shukla.

The Secretary is authorized to determine by regulation what claims are covered by the act (42 U.S.C., § 1395ff(a)), and the regulations provide that a final decision is not rendered on a claim until it is pursued through a multi-level review process.

Judicial review is available as provided in 42 United States Code section 405(g), a provision found in a different part of the Social Security Act but incorporated into the Medicare Act. (42 U.S.C., § 1395ff(b).) Section 405(g) provides that a final decision may be reviewed by a civil action which "shall" be brought in the appropriate United States District Court. Thus, the question is whether the McCalls' claims arose under the Medicare Act. If so, they were required to first exhaust their administrative remedies and could thereafter only seek judicial review in federal court.

Consideration of when a claim arises under the Medicare Act must begin with the seminal decision of *Heckler v. Ringer* (1984) 466 U.S. 602, 104 S.Ct. 2013, 80 L.Ed.2d 622, which held the substance of the claim controls. In *Heckler*, four individuals sought a declaration that the Secretary was legally obliged to authorize or reimburse them for surgery not covered under Medicare regulations. They also requested an injunction to compel payment and to bar the Secretary from requiring them to exhaust their administrative remedies. Three of the four plaintiffs had undergone surgery and filed administrative claims for reimbursement, but had not received a final decision. The fourth had not had surgery and sought authorization for the procedure. All contended their constitutional rights were violated by requiring them to go through a multi-layered administrative review process and asserted the Secretary was legally required to reimburse them or authorize surgery. They characterized their challenge to the administrative process as a procedural claim and not one for benefits, pointing out they sought only declaratory and injunctive relief. (*Heckler, supra*, 466 U.S. at pp. 609-611, 104 S.Ct. 2013.)

The *Heckler* court held claims arising under the Medicare Act "include any claims in which 'both the standing and the substantive basis for the presentation' of the claims" was the Medicare Act. (*Heckler*, *supra*, 466 U.S. at p. 615, 104 S.Ct. 2013.) As applied to the individuals seeking reimbursement for surgery, the court found their claims arose under the act. That they sought only declaratory and injunctive relief was of no import, for "[f]ollowing the declaration which respondents seek from the Secretary—that [their] surgery is a covered service—only essentially ministerial details will remain before respondents would receive reimbursement." (*Ibid.*)

As for the individual awaiting surgery, the court held his claim too arose under the act, because he was seeking to establish a right to future payments should he decide to go ahead with surgery. "The claim for future benefits must be construed as a 'claim arising under' the Medicare Act because any other construction would allow claimants substantially to undercut Congress's carefully crafted scheme for administering the Medicare Act." (*Heckler*, *supra*, 466 U.S. at p. 621, 104 S.Ct. 2013.)

Redmond v. Secure Horizons, Pacificare, Inc., *supra*, 60 Cal.App.4th 96, 70 Cal.Rptr.2d 174 (*Redmond*), was, like *Heckler*, a reimbursement case. Redmond, an HMO subscriber, requested reimbursement for surgery. The HMO first turned her down but later paid the claim. Redmond alleged the HMO knew the claim was covered but nonetheless initially denied it and then delayed reimbursement. She sued for breach of contract, breach of the implied covenant of good faith and fair dealing, and intentional and negligent infliction of emotional harm, claiming loss of use of the money, emotional suffering and attorney fees. (*Id.* at p. 99, 70 Cal.Rptr.2d 174.) The court characterized Redmond's claim as one for benefits under the Medicare Act and held it had no jurisdiction. It reasoned that "while plaintiff's causes of action are not actually a claim for

benefits . . . her causes of action *are* 'inextricably intertwined' with a claim that she was entitled to the reimbursement she received. . . . [T]he alleged wrongfulness of defendant's conduct depends on whether plaintiff was entitled to payment of her claim. The fact that defendant ultimately paid her claim does not necessarily establish that plaintiff was *entitled* to such payment." (*Redmond, supra*, 60 Cal.App.4th. at p. 102, 70 Cal.Rptr.2d 174.)

We agree with the outcome in *Redmond* but find the case distinguishable. The essence of Redmond's claim was a denial of benefits, albeit for delayed reimbursement rather than the cost of medical care. Just as couching a reimbursement claim as one for declaratory or injunctive relief did not alter that basic fact in *Heckler*, we think the *Redmond* court properly held that couching a reimbursement claim as one for breach of contract is no more availing.

However, this is a different case. The McCalls' action is not in substance a claim for reimbursement of benefits, even though *some* of damages sought fall into that category (past and future medical expenses.) We cannot agree with *Redmond's* suggestion that all claims which *depend* upon entitlement to benefits arise under the Medicare Act. As noted by amicus curiae the American Association of Retired Persons, this goes too far in implying that any problem over health care covered by the Medicare insurance program is so related to a benefit claim that it may only proceed via the administrative process. We therefore turn to federal cases that consider the proper forum in which to adjudicate non-reimbursement claims against health care providers.

Where a state law claim is brought against an HMO, even if the claim is based on a denial of Medicare benefits, federal courts distinguish *Heckler* and allow the action to proceed in state court. (*Ardary v. Aetna Health Plans of California, Inc.* (9th Cir.1996) 98 F.3d 496, certiorari denied 520 U.S. 1251, 117 S.Ct. 2408, 138 L.Ed.2d 174 [wrongful death action for

negligence, intentional and negligent infliction of emotional distress, misrepresentation and professional negligence]; *Plocica v. Nylcare of Texas, Inc.* (N.D.Tex.) 43 F.Supp.2d 658 [wrongful death action for negligence]; *Winkler v. Interim Services, Inc.* (M.D.Tenn.1999) 36 F.Supp.2d 1026 [action for refusal to provide care in order to save money, alleging breach of contract, infliction of emotional harm and negligence along with federal and state statutory claims]; *Wartenberg v. Aetna U.S. Healthcare, Inc.* (E.D.N.Y.1998) 2 F.Supp.2d 273 [wrongful death action for negligence]; *Berman v. Abington Radiology Associates, Inc.* (E.D.Pa. Aug. 14, 1997) (docket no. Civ. A. 97-3208) 1997 WL 534804 [negligence].)

Ardary v. Aetna Health Plans of California, Inc., supra, 98 F.3d 496 (*Ardary*) is the leading case. Cynthia Ardary died at a rural hospital after her HMO refused to authorize an airlift to a larger institution with intensive care facilities. Ardary's heirs brought a wrongful death action against the HMO for negligence, emotional distress, misrepresentation and professional negligence. Although the complaint did not seek recovery of Medicare benefits, the Ardarys conceded their claims were "predicated on" the HMO's failure to authorize the airlift. (*Ardary, supra*, 98 F.3d at pp. 497- 498.) The action was initially filed in state court and removed to federal court by the HMO, where the district judge granted its motion to dismiss for failure to exhaust administrative remedies. (*Ardary, supra*, 98 F.3d at p. 498.)

The Ninth Circuit held the Ardarys' claims did not arise under the Medicare Act and remanded the case to state court. It found *Heckler* inapplicable, reasoning the claims were based on state law and did not seek reimbursement for Medicare covered benefits, hence neither the standing nor substance was based on the Medicare Act. The court also noted Cynthia's death could not be remedied by the retroactive authorization of, or payment for, the airlift, so for

this additional reason the action could not be considered one for reimbursement of benefits. (*Ardary, supra*, 98 F.3d at p. 500.) The court was reluctant to find state law preempted by the Medicare Act absent a clear Congressional intent, and found nothing in the legislative history of the act that suggested it was designed to abolish all state remedies for torts committed by a Medicare provider. (*Id.* at p. 501.)

We agree with *Ardary* that state law claims which do not seek reimbursement for Medicare benefits do not arise under the Medicare Act, and are actionable in state court. The McCalls' complaint cannot be characterized as one for reimbursement of benefits simply because the damages sought include past and future medical expenses incurred because McCall was denied a lung transplant. Those damages are not recoverable in a state action,[2] but their inclusion in the complaint does not transmogrify the action into one for reimbursement and deprive the state court of jurisdiction.

The negligence alleged is failure to recommend or provide needed care. Apart from medical expenses, McCall seeks compensation for his worsened condition, and there is no suggestion this is covered by Medicare. The fraud causes of action do not involve claims for benefits, nor do the emotional suffering allegations that Pacificare and GNP's conduct was outrageous and beyond what is socially

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[2] McCall was covered by Medicare, he was entitled to benefits, and he cannot avoid the administrative exhaustion requirement and the limitation to judicial review of benefit claims in the federal courts by joining such claims with state law tort claims.

Elimination of the medical expenses from this action should pose no difficulty. McCall states in his brief that after he was disenrolled from Pacificare, GNP referred him for a lung transplant evaluation, he was approved, and is awaiting a donor. McCall asserts in general terms Medicare "will pay for it," and argues he therefore has no reason to seek reimbursement in this action. We agree.

acceptable in causing McCall and his wife emotional suffering and anguish. And it is a stretch too far to say an unfair business practices claim for violation of state law arises under the Medicare Act. Admittedly all of these causes of action are predicated on Pacificare and GNP's failure to provide benefits. But here we find *Ardary* more persuasive than *Redmond*, and we share the former's concern that "removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients." (*Ardary, supra*, 98 F.3d at p. 501.) So leave to file an amended complaint should have been granted.

II

McCall argues the trial judge was mistaken in concluding a physician provider group is not vicariously liable for the negligence of one of its members, and we agree. Health and Safety Code section 1371.25 [3] does not shield GNP from vicarious liability for Shukla's negligence. It is intended only to prohibit an HMO such as Pacificare from demanding indemnity for its own misconduct.

Section 1371.25, enacted in 1995, provides in full as follows: "A plan, any entity contracting with a plan, and providers are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in a contract with providers is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part of a plan, any entity contracting with a plan, or a provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability."

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[3] All further statutory references are to the Health and Safety Code.

As defined in section 1371.25, Pacificare is a plan [4] and GNP is a provider.[5] We construe the first two sentences of section 1371.25 to prohibit plans from demanding indemnity against their own acts or omissions in contracts with their providers. The third sentence reaffirms that plans, contractors and providers—like GNP—remain liable under common law doctrines such as vicarious liability. The legislative history of section 1371.25 shows the Legislature was concerned about plans that required providers to hold them harmless from liability where the plan denied services to a patient, but wanted to reaffirm that plans were not liable for provider negligence or vice-versa.

The Senate Insurance Committee report states "[s]ome plan contracts with providers propose provisions to hold plans harmless from liability in cases where the plan has denied services and the patient has suffered harm. A[ssembly] B[ill No.] 1840 [later codified as section 1371.25] is intended to outlaw such provisions and to ensure that plans are held responsible for the results of their medical decisions. . . . [P]lans are not responsible for liability arising from provider negligence or malpractice."

Likewise, a Senate Judiciary Committee report provides "[t]he sponsors contend that the health plans should be responsible for adverse results of their actions in the same

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[4] Section 1345, subdivision (q) states a "plan" refers to health care service plans, and section 1345, subdivision (f)(1) provides the latter includes "[a]ny person who undertakes to arrange for the provision of health care services to subscribers or enrollees . . . in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees." A corporation is included within the definition of "person" (§ 1345, subd. (j)), and it is alleged Pacificare is a California corporation.

[5] Section 1345, subdivision (i) states a provider includes "any . . . organization . . . or other person . . . licensed by the state to deliver or furnish health care services." As noted in footnote 4, this includes a corporation, and it is alleged GNP is a corporation in the business of providing medical care to patients.

manner as providers are liable for their negligence. [¶] This provision addresses an issue raised at a recent special hearing of this committee on managed health care. Complaints were raised by various health care providers . . . that some managed care provider contracts contained 'hold harmless' clauses which operated to shift from the plan to the provider any liability arising out of the provision of care under the plan, even if the actions of the plan (e.g., denial of treatment) contributed to the injury. . . . [T]his ameliorative legislation [ ] specif[ies] that health plans are not responsible for liability arising from provider negligence or malpractice just as providers are not liable for the negligence of the health plan."

GNP tries to turn the statute to its advantage by arguing it is a plan but we don't buy it. McCall alleges GNP is a corporation in the business of providing medical care to patients, and Shukla is an officer, director and employee of GNP. This places GNP within the statutory definition of a provider. (Ante, fn. 5.) The trial judge should have overruled the demurrer to McCall's claim GNP was vicariously negligent for Shukla's negligence.

[The following part was not published]

III

GNP argues the demurrer to the intentional infliction of emotional distress cause of action and two of the fraud causes of action should be sustained on other grounds. We agree only as to the emotional distress claim (the seventh cause of action).

A

GNP is correct that McCall fails to state a claim for intentional infliction of emotional distress because he does not allege GNP intended to cause him emotional suffering. The tort of intentional infliction of emotional distress requires proof of: (1) extreme and outrageous conduct by the

defendant with the intention of causing, or reckless disregard of the probability of causing, emotional distress; (2) severe or extreme emotional distress actually suffered; and (3) causation. (*KOVR-TV, Inc.* v. *Superior Court* (1995) 31 Cal.App.4th 1023, 1028.) The requisite intent is not alleged, but McCall should be given leave to amend.

B

GNP is wrong when it argues the fifth cause of action for fraud fails because it does not specify who made the statement, whether it was oral or written, and facts establishing the speaker had the capacity to bind the entity by his statements. (*Mason* v. *Drug, Inc.* (1939) 31 Cal.App.2d 697). Nor is it correct in contending McCall fails to allege reliance, injury or causation.

The fifth cause of action alleges GNP defrauded Pacificare by making misrepresentations, "some of which are contained in its provider agreement with Pacificare," that it would give Pacificare members care required under enumerated sections of California law and federal law. McCall alleges GNP made the representations to induce Pacificare to select it as a provider, Pacificare relied on the statements in choosing GNP, and GNP knew the misrepresentations presented a foreseeable risk of substantial physical injury to plan enrollees like himself. He incorporates by reference allegations that as the "direct and proximate cause" of defendant's conduct, he sustained injury.

McCall appears to limit his allegations of fraud to the provider agreement when he takes the position that the fraudulent representations "are set forth in an agreement to which GNP is a party." This establishes the representations were written, and the document will reveal the utterer and whether that individual had the capacity to bind GNP. The complaint alleges reliance by Pacificare and foreseeable injury to its enrollees, including McCall (*Randi W.* v. *Muroc*

Joint Unified School Dist. (1997) 14 Cal.4th 1066, 1077), and under *Randi W.* "plaintiff need only allege that her injury resulted from action that *the recipient* of defendants' misrepresentation took in reliance on them." (*Id.* at p. 1085.) Causation is also alleged. So the fifth cause of action is adequate.

C

GNP is again mistaken when it argued the sixth cause of action for fraudulent concealment fails to state a claim. It contends there is nothing illegal about Pacificare making capitation payments to it, not entering into a shared risk arrangement that is not tied to specific medical decisions about specific enrollees, for both are allowed by section 1348.6. This ignores the point. The allegation is that GNP concealed it "failed to take steps to insulate medical decision making from fiscal and administrative concerns." Put otherwise, McCall alleges GNP failed to advise him it could make choices about what care to give him based on its own financial interest and not his medical needs. And, McCall alleges, it did just that when it denied him care because it would cost too much. That states a claim.

[The following holding was published]

DISPOSITION

The judgment is reversed.

SILLS, P.J., and RYLAARSDAM, J., concur.

APPENDIX C

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

[Filed Aug. 12, 1998]

Case No. 788545

GEORGE MCCALL AND BARBARA MCCALL,
Plaintiffs,

v.

PACIFICARE OF CALIFORNIA, INC., a California Corporation dba "Secure Horizons"; PACIFICARE HEALTH SYSTEMS, INC.; a Delaware Corporation dba "Secure Horizons"; GREATER NEWPORT PHYSICIANS, INC., a California Corporation; LAKSHMI SHUKLA; and DOES 1-15, inclusive,
Defendants.

Date Complaint Filed: 12/29/97
Trial Date: None Set

NOTICE OF ENTRY OF JUDGMENT

TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD:

NOTICE IS HEREBY GIVEN that on July 8, 1998, at 1:30 a.m. in Department 24 of the above-entitled court, the hearing on defendants PacifiCare of California dba Secure Horizons and PacifiCare Health Systems, Inc.'s demurrer to and motion to strike portions of plaintiffs' First Amended Complaint came on regularly for hearing before the Honorable Thierry P. Colaw, Judge.

After considering all of the moving and opposition papers, arguments of the parties and taking the matter under submission, on July 16, 1998, the Court issued a Minute

Order sustaining the demurrer to First Amended Complaint without leave to amend. The Court denied the motion strike as moot in light of the Court's ruling on the demurrer. Pursuant to *Code of Civil Procedure*, Section 581(d), judgment was entered at that time. A conformed copy of Judge Colaw's order is attached to this Notice.

DATED: August 10, 1998

KONOWIECKI & RANK

By /s/ Keith A. Weaver
KEITH A. WEAVER
Attorneys for Defendants,
PacifiCare of California dba Secure Horizons
and PacifiCare Health Systems, Inc.

APPENDIX D

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

[Filed Aug. 4, 1998]

Case No. 788545

GEORGE MCCALL AND BARBARA MCCALL,
Plaintiffs,

v.

PACIFICARE OF CALIFORNIA, INC., a California Corporation dba "Secure Horizons"; PACIFICARE HEALTH SYSTEMS, INC., a Delaware Corporation dba "Secure Horizons"; GREATER NEWPORT PHYSICIANS, INC., a California Corporation; LAKSHMI SHUKLA; and DOES 1-15, inclusive,
Defendants.

Date Complaint Filed: 12/29/97
Trial Date: None Set

ORDER RE DEFENDANTS PACIFICARE OF CALIFORNIA dba SECURE HORIZONS AND PACIFICARE HEALTH SYSTEMS, INC.'S DEMURRER TO PLAINTIFFS' FIRST AMENDED COMPLAINT

The Demurrer to plaintiff's First Amended Complaint, brought by Defendants PacifiCare of California dba Secure Horizons and PacifiCare Health Systems, Inc. came on regularly for hearing on July 8, 1998 at 1:30 p.m. in Department 24 of the above-entitled court, the Honorable Thierry P. Colaw, Judge, Presiding.

Plaintiffs, George McCall and Barbara McCall, were represented through counsel, Carol Jimenez and Russell S. Balisok; Keith A. Weaver appeared on behalf of defendants PacifiCare of California d/b/a Secure Horizons.

The Court took the matter under submission and upon full consideration of all points and authorities filed in support of, and in opposition to the demurrer, and following oral argument, the court sustained the demurrer to the entire First Amended Complaint, without leave to amend. (The Court's Minute Order is Attached as Exhibit "A.")

IT IS HEREBY ORDERED, adjudged and decreed, that the defendants' demurrer to plaintiffs' First Amended Complaint is sustained, in its entirety, without leave to amend.

IT IS FURTHER ORDERED, adjudged and decreed, that the plaintiffs' First Amended Complaint is therefore dismissed in its entirety as to defendant PacifiCare of California, Inc. dba Secure Horizons and PacifiCare Health Systems, Inc. dba Secure Horizons only per *this* order.

IT IS SO ORDERED.

Dated: 8/4/98, 1998

By /s/ Thierry P. Colaw
THIERRY P. COLAW
JUDGE OF THE SUPERIOR COURT

EXHIBIT "A"

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

MINUTE ORDER

Dept. 24

Court convened at____m. July 16, 1998

Hon. Thierry P. Colaw, Judge; C. Falkenberg, Deputy Clerk

None_____, Bailiff; None_____, Reporter;

and the following proceedings were had;

78 85 45 McCALL VS PACIFICARE OF CALIFORNIA, INC.

No appearances. This matter having been taken under submission on 7-8-98, the Court hereby rules as follows:

1. Pacificare's Demurrer to the 1st Amended Complaint is SUSTAINED without leave to amend.

A. The claims and causes of action of the 1st Amended Complaint are inextricably intertwined with a claim for a denial of benefits (i.e. medical services) to George McCall placing the matter under the Medicare Act with the requirement of exhaustion of administrative remedies and subject to the exclusive jurisdictional provisions of that Act.

B. The wrongfulness of the defendant's conduct depends directly on whether McCall was entitled to the benefits sought so as to require this Court to make a Medicare benefits determination which is reserved for the administrative process and if necessary the Federal District Court only.

C. *Redmond v Secure Horizons*(1997) 60 Cal App. 4th 96 is controlling. *Solorzano v Superior Court* (1992) 10 Cal App 4th 1135 and *Podolsky v First Healthcare*(1996) 50 Cal App 4th 632 are distinguishable.

2. Pacificare's Motion to Strike is DENIED as Moot given the Court's ruling on the Demurrer.

3. Greater Newport Physicians Inc.'s Demurrer to the 1st Amended Complaint is SUSTAINED without leave to amend.

A. Plaintiffs' claims against GNP arise under the Pacificare/Secure Horizons contract and are thus likewise governed by the Medicare administrative appeal process.

B. 42 U.S.C. Section 1395ff(a) provides factual determinations and any other determination with respect to a claim for benefits against *anyone* in any action in which such a determination is a necessary predicated fact must be decided under the Medicare appeal process system. The plaintiffs' claims against GNP are based upon benefit determintions thus this Court lacks subject matter jurisdiction.

C. To the extent plaintiffs' claims are based upon defendant Shukla's alleged malpractice the claims fail in light of H&S Section 1371.25. As a matter of Law GNP cannot be vicariously liable for Shukla's negligence.

4. GNP's Motion to Strike is DENIED as Moot given the Court's ruling on the Demurrer.

Clerk to give notice. ENTERED 7-16-98.

"See attached Service List"

CLERK'S CERTIFICATE OF MAILING (CCP 1013a)—I certify I am not a party to this cause, over age 18, and a copy of this document was mailed first class postage prepaid in a

sealed envelope addressed as shown. Mailing and execution of this certificate occurred on ____7-16-98 _____, ,at Santa Ana, California.

ALAN SLATER EXEC. OFFICER/CLERK By:
CHRISTINE FALKENBURG, DEPUTY

APPENDIX E

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

[Filed Aug. 4, 1998]

Case No. 788545
[Hon. Thierry P. Colaw, Judge]

GEORGE MCCALL AND BARBARA MCCALL,
Plaintiffs,

v.

PACIFICARE OF CALIFORNIA, INC., a California Corporation dba "Secure Horizons"; PACIFICARE HEALTH SYSTEMS, INC., a Delaware Corporation dba "Secure Horizons"; GREATER NEWPORT PHYSICIANS, INC. a California Corporation; LAKSHMI SHUKLA; and DOES 1-15, inclusive,
Defendants.

[AMENDED PROPOSED] ORDER GRANTING JUDGMENT OF DEFENDANT GREATER NEWPORT PHYSICIANS, INC. AFTER SUSTAINING DEMURRER TO PLAINTIFFS' FIRST AMENDED COMPLAINT WITHOUT LEAVE TO AMEND

The Demurrer of Defendant GREATER NEWPORT PHYSICIANS, INC. ("GNP") to the First Amended Complaint of Plaintiffs GEORGE McCALL and BARBARA McCALL ("Plaintiffs") came on regularly for hearing before this Court on July 8, 1998.

After considering the moving and opposition papers, arguments of counsel, and all other matters presented to the Court, and good cause appearing, the Court sustains GNP's Demurrer without leave to amend on the following grounds:

1. The claims and causes of action of the First Amended Complaint are inextricably intertwined with a claim for denial of benefits (*i.e.*, medical services) to GEORGE McCALL, placing the matter under the Medicare Act with the requirement of exhaustion of administrative remedies and subject to the exclusive jurisdictional provisions of that Act.

2. The wrongfulness of the GNP's conduct depends directly on whether GEORGE McCALL was entitled to the benefits sought so as to require this Court to make a Medicare benefits determination which is reserved for the administrative process and if necessary the federal district court only.

3. *Redmond v. Secure Horizons* (1997) 60 Cal. App. 4th 96 is controlling. *Solorzano v. Superior Ct.* (1992) 10 Cal. App. 4th 1135, and *Podolsky v. First Healthcare* (1996) 50 Cal. App. 4th 632 are distinguishable.

4. Plaintiffs' claims against GNP arise under the Pacificare/Secure Horizons contract and are governed by the Medicare administrative appeal process.

5. Title 42, United States Code, section 1395ff(a) provides factual determinations and any other determination with respect to a claim for benefits against *anyone* in any action in which such a determination is a necessary predicate fact must be decided under the Medicare appeal process system. Plaintiffs' claims against GNP are based upon benefit determinations, and thus this Court lacks subject matter jurisdiction.

6. To the extent that Plaintiffs' claims are based upon defendant Shukla's alleged malpractice, the claims fail in light of California Health and Safety Code section 1371.25. As a matter of law, GNP cannot be vicariously liable for Shukla's negligence.

The Court further determines that it is appropriate to dismiss this action against GNP and to render judgment in favor of GNP and against Plaintiffs as permitted by section 579 of the California Code of Civil Procedure.

IT IS THEREFORE ORDERED that GNP's Demurrer to the First Amended Complaint is SUSTAINED without leave to amend, and that GNP shall be dismissed from this action and Judgment shall be entered forthwith in favor of GNP and against Plaintiffs, that Plaintiffs shall take nothing against GNP by reason of the First Amended Complaint herein, and that GNP shall recover its costs pursuant to Code of Civil Procedure section 1032.

IT IS SO ORDERED.

Thierry Patricia Colaw
JUDGE OF THE SUPERIOR COURT

Aug. 04 1998

APPENDIX F

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

[Filed Aug. 3, 1998]

Case No. 788545
[Hon. Thierry P. Colaw, Judge]

GEORGE MCCALL AND BARBARA MCCALL,
Plaintiffs,

v.

PACIFICARE OF CALIFORNIA, INC., a California Corporation dba "Secure Horizons"; PACIFICARE HEALTH SYSTEMS, INC., a Delaware Corporation dba "Secure Horizons"; GREATER NEWPORT PHYSICIANS, INC. a California Corporation; LAKSHMI SHUKLA; and DOES 1-15, inclusive,
Defendants.

ORDER GRANTING JUDGMENT OF DEFENDANT GREATER NEWPORT PHYSICIANS, INC. AFTER SUSTAINING DEMURRER TO PLAINTIFFS' FIRST AMENDED COMPLAINT WITHOUT LEAVE TO AMEND

The Demurrer of Defendant GREATER NEWPORT PHYSICIANS, INC. ("GNP") to the First Amended Complaint of Plaintiffs GEORGE McCALL and BARBARA McCALL ("Plaintiffs") came on regularly for hearing before this Court on July 8, 1998.

After considering the moving and opposition papers, arguments of counsel, and all other matters presented to the Court, and good cause appearing, the Court sustains GNP's Demurrer without leave to amend on the following grounds:

1. The claims and causes of action of the First Amended Complaint are inextricably intertwined with a claim for denial of benefits (*i.e.*, medical services) to GEORGE McCALL, placing the matter under the Medicare Act with the requirement of exhaustion of administrative remedies and subject to the exclusive jurisdictional provisions of that Act.

2. The wrongfulness of the GNP's conduct depends directly on whether GEORGE McCALL was entitled to the benefits sought so as to require this Court to make a Medicare benefits determination which is reserved for the administrative process and if necessary the federal district court only.

3. *Redmond v. Secure Hirozons* (1997) 60 Cal. App. 4th 96 is controlling. *Solorzano v. Superior Ct.* (1992) 10 Cal. App. 4th 1135, and *Podolsky v. First Healthcare* (1996) 50 Cal. App. 4th 632 are distinguishable.

4. Plaintiffs' claims against GNP arise under the Pacificare/Secure Horizons contract and are governed by the Medicare administrative appeal process.

5. Title 42, United States Code, section 1395ff(a) provides factual determinations and any other determination with respect to a claim for benefits against *anyone* in any action in which such a determination is a necessary predicate fact must be decided under the Medicare appeal process system. Plaintiffs' claims against GNP are based upon benefit determinations, and thus this Court lacks subject matter jurisdiction.

6. To the extent that Plaintiffs' claims are based upon defendant Shukla's alleged malpractice, the claims fail in light of California Health and Safety Code section 1371.25. As a matter of law, GNP cannot be vicariously liable for Shukla's negligence.

The Court further determines that it is appropriate to render judgment in favor of GNP and against Plaintiffs as permitted by section 579 of the California Code of Civil Procedure.

IT IS THEREFORE ORDERED that GNP's Demurrer to the First Amended Complaint is SUSTAINED without leave to amend, and that Judgment shall be entered forthwith in favor of GNP and against Plaintiffs, that Plaintiffs shall take nothing against GNP by reason of the First Amended Complaint herein, and that GNP shall recover its costs pursuant to Code of Civil Procedure section 1032.

IT IS SO ORDERED.

Thierry Patricia Colaw
JUDGE OF THE SUPERIOR COURT

Aug. 03 1998

APPENDIX G

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF ORANGE

[Filed Aug. 6, 1998]

Case No. 788545
[Hon. Thierry P. Colaw, Judge]

GEORGE MCCALL AND BARBARA MCCALL,
Plaintiffs,

v.

PACIFICARE OF CALIFORNIA, INC., a California Corporation dba "Secure Horizons"; PACIFICARE HEALTH SYSTEMS, INC., a Delaware Corporation dba "Secure Horizons"; GREATER NEWPORT PHYSICIANS, INC. a California Corporation; LAKSHMI SHUKLA; and DOES 1-15, inclusive,
Defendants.

NOTICE OF ENTRY OF JUDGMENT

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that on this date Judgment was entered in the above-entitled action in favor of Defendant GREATER NEWPORT PHYSICIANS, INC. and against Plaintiffs GEORGE McCALL and BARBARA McCALL

APPENDIX H

42 U.S.C. § 405. Evidence, procedure, and certification for payments

* * * *

(g) Judicial review

Any individual, after any final decision of the Commissioner of Social Security made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Commissioner of Social Security may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of the Commissioner's answer the Commissioner of Social Security shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing. The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Commissioner of Social Security or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Commissioner of Social Security, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the

question of conformity with such regulations and the validity of such regulations. The court may, on motion of the Commissioner of Social Security made for good cause shown before the Commissioner files the Commissioner's answer, remand the case to the Commissioner of Social Security for further action by the Commissioner of Social Security, and it may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding; and the Commissioner of Social Security shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm the Commissioner's findings of fact or the Commissioner's decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which the Commissioner's action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Commissioner of Social Security or any vacancy in such office.

(h) Finality of Commissioner's decision

The findings and decision of the Commissioner of Social Security after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United

States, the Commissioner of Social Security, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

* * * *

(Aug. 14, 1935, c. 531, Title II, § 205, 49 Stat. 624; Aug. 10, 1939, c. 666, Title II, § 201, 53 Stat. 1368; 1946 Reorg. Plan No. 2, § 4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; June 25, 1948, c. 646, § 32(b), 62 Stat. 991; May 24, 1949, c. 139, § 127, 63 Stat. 107; Aug. 28, 1950, c. 809, Title I, §§ 101(b)(2), 108(a) to (c), 109(b), 64 Stat. 488, 518, 523; July 18, 1952, c. 945, § 5(b), 66 Stat. 775; 1953 Reorg. Plan No. 1, §§ 5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Sept. 1, 1954, c. 1206, Title I, § 101(a)(5), (c)(3), 68 Stat. 1052, 1054; Aug. 1, 1956, c. 836, Title I, §§ 107(b), 111(a), 117, 70 Stat. 829, 831, 834; Aug. 1, 1956, c. 837, Title IV, § 402(b), 70 Stat. 871; June 11, 1960, Pub.L. 86-507, § 1(35), 74 Stat. 202; Sept. 13, 1960, Pub.L. 86-778, Title I, §§ 102(f)(2), 103(j)(2)(E), Title VII, § 702(a), 74 Stat. 933, 938, 993; Sept. 22, 1961, Pub.L. 87-293, Title II, § 202(b)(3), 75 Stat. 626; July 30, 1965, Pub.L. 89-97, Title III, §§ 308(d)(9), (10), 330, 79 Stat. 379, 401; Jan. 2, 1968, Pub.L. 90-248, Title I, § 171(a), 81 Stat. 876; Oct. 15, 1970, Pub.L. 91-452, Title II, § 236, 84 Stat. 930; Oct. 30, 1972, Pub.L. 92-603, Title I, § 137, 86 Stat. 1364; Oct. 16, 1974, Pub.L. 93-445, Title III, §§ 302(a), 303, 88 Stat. 1358; Jan. 2, 1976, Pub.L. 94-202, § 4, 89 Stat. 1136; Oct. 4, 1976, Pub.L. 94-455, Title XII, § 1211(b), 90 Stat. 1711; Dec. 20, 1977, Pub.L. 95-216, Title III, § 353(f)(2), 91 Stat. 1554; Nov. 6, 1978, Pub.L. 95-600, Title VII, § 703(j)(14)(B), 92 Stat. 2942; Oct. 17, 1979, Pub.L. 96-88, Title V, § 509(b), 93 Stat. 695; June 9, 1980, Pub.L. 96-265, Title III, §§ 305(a), 307, 94 Stat. 457, 458; Jan. 12, 1983, Pub.L. 97-455, § 4(a), 96 Stat. 2499; Apr. 20, 1983, Pub.L. 98-21, Title III, §§ 301(d), 309(i), 336, 345(a), 97 Stat. 111, 117, 130, 137; July 18, 1984, Pub.L. 98-369, Div.B, Title VI, §§ 2661(h), 2663(a)(4),

(j)(4), 98 Stat. 1157, 1162, 1171; Oct. 9, 1984, Pub.L. 98-460, § 16(a), 98 Stat. 1809; Oct. 21, 1986, Pub.L. 99-509, Title IX, § 9002(c)(2)(A), (B), 100 Stat. 1971; Oct. 13, 1988, Pub.L. 100-485, Title I, § 125(a), 102 Stat. 2353; Nov. 10, 1988, Pub.L. 100-647, Title VIII, §§ 8008(a), 8009(a), 8015(a)(1), 8016(a)(1), 102 Stat. 3783, 3787, 3790, 3792; Dec. 19, 1989, Pub.L. 101-239, Title X, §§ 10303(a), 10304, 103 Stat. 2482, 2483; Nov. 5, 1990, Pub.L. 101-508, Title V, §§ 5105(a)(1)(A), (2)(A)(i), (3)(A)(i), (b)(1), (c)(1), (d)(1)(A), 5107(a)(1), 5109(a)(1), 104 Stat. 1388-254, 1388-260, 1388-263, 1388-265, 1388-269, 1388-271; Nov. 28, 1990, Pub.L. 101-624, Title XVII, § 1735(a), (b), Title XXII, § 2201(b), (c), 104 Stat. 3791, 3792, 3951, 3952; Aug. 15, 1994, Pub.L. 103-296, Title I, § 107(a)(1), (2), (4), Title II, §§ 201(a)(1)(A), (B), (2)(A) to (C), 206(a)(1), (d)(1), Title III, §§ 304(a), 316(a), 318, 321(a)(7) to (11), (c)(3), (6)(B), (f)(2)(A), 108 Stat. 1477, 1478, 1490, 1492 to 1494, 1509, 1514, 1520, 1531, 1533, 1536, 1538, 1541; Mar. 29, 1996, Pub.L. 104-121, Title I, § 105(a)(2), 110 Stat. 852; Aug. 22, 1996, Pub.L. 104-193, Title I, § 108(a)(1), 110 Stat. 2164; Aug. 5, 1997, Pub.L. 105-34, Title X, § 1090(b)(1), 111 Stat. 962; Dec. 14, 1999, Pub.L. 106-169, Title II, § 251(b)(2), 113 Stat. 1854.)

APPENDIX I

SUPERIOR COURT OF THE STATE OF CALIFORNIA
COUNTY OF ORANGE

[Filed May 8, 1998]

Case No.: 788545
Judge Thierry P. Colaw

GEORGE MCCALL and BARBARA MCCALL,
Plaintiffs,

v.

PACIFICARE OF CALIFORNIA, INC., a California Corporation dba "Secure Horizons"; PACIFICARE HEALTH SYSTEMS, INC., a Delaware Corporation dba "Secure Horizons"; GREATER NEWPORT PHYSICIANS, INC., a California Corporation; LAKSHMI SHUKLA; and DOES 1-15, inclusive,
Defendants.

FIRST AMENDED COMPLAINT FOR DAMAGES:

—NEGLIGENCE

—WILLFUL MISCONDUCT

—FRAUD (3 COUNTS)

—CONSTRUCTIVE FRAUD

—INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

—NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS

—UNFAIR BUSINESS PRACTICES

COME NOW, Plaintiffs George McCall and Barbara McCall who for a complaint allege as follows:

GENERAL ALLEGATIONS

1. At all times herein mentioned, Plaintiffs GEORGE McCALL ("GEORGE") and BARBARA McCALL ("BARBARA") have been, and are, husband and wife, and individuals residing together in the County of Orange, State of California.

2. The events and occurrences as hereinafter alleged occurred principally in Orange County.

3. Defendant PACIFICARE OF CALIFORNIA is a California Corporation. Defendant PACIFICARE HEALTH SYSTEMS, INC., is a Delaware Corporation. Each of said corporations does business under the name "Secure Horizons" and is either in business throughout various locales in the State of California, including Orange County as a "health care service plan" or health maintenance organization ("HMO") duly licensed by the State of California Department of Corporations ("DOC"); or is the parent of; or, alternatively, has or will merge with such co-defendant corporation doing business as an HMO. Each such corporation will be referred to hereinafter collectively as "PACIFICARE" and each is responsible for the injuries and has engaged in the conduct hereinafter ascribed to PACIFICARE.

4. As a California licensed HMO, PACIFICARE fulfills the separate roles of health care insurer and health care provider and PACIFICARE agreed to and is required to provide and pay for a certain range of health care services for each enrollee's medical needs as well as to comply with and provide a certain range of protections designed to protect enrollees from an HMO's potential abuse of the system and its potential abuse of its dual rule as health care insurer and health care provider.

5. And as a full service HMO providing health care coverage to persons entitled to participate in the federal Medicare Program, such as GEORGE, PACIFICARE was

required to and did enter into an agreement with the federal Department of Health and Human Services ("DHHS") pursuant to which, for a predetermined and agreed payment from DHHS to PACIFICARE each month for persons who enroll as plan participants, PACIFICARE agreed to comply with a range of rules designed to protect enrollees from potential abuses of the system by the HMO.

6. Accordingly, PACIFICARE has a clear interest in providing enrollees with medical care in accord with an enrollee's needs according to the law, on one hand, and a clear financial interest in limiting the cost and amount of said care, on the other hand. Rather than fulfill obligations under the law and its license from DOC, however, PACIFICARE passes on or "lays off" the financial risk of providing care and fulfilling its obligations to its enrollees by contracting with "independent" health care providers to provide required care, for a predetermined monthly payment per plan enrollee. This per person/per month payment is called a "capitation" payment or fee. If an enrollee's medical condition cannot be treated by the health care providers with which PACIFICARE has contracted, and a patient must be referred to health care providers outside of the HMO or provider group, the cost of such care is ordinarily paid for by such health care providers without additional payment from PACIFICARE.

7. Prior to the events and occurrences which caused injury to GEORGE and BARBARA, as hereinafter alleged, GEORGE enrolled with PACIFICARE as a member, paid premiums or caused others to pay such premiums on his behalf, and thereby became eligible to receive medical care and treatment from PACIFICARE at no additional cost to him. By accepting GEORGE as an enrolled member, PACIFICARE agreed to render a full range of care to GEORGE without cost (except for occasional nominal co-payments), and acknowledged that the care rendered to

GEORGE would meet the requirements expressed in the law, as well as the terms of GEORGE's enrollment agreement with PACIFICARE.

8. PACIFICARE had previously entered into an agreement with Defendant GREATER NEWPORT PHYSICIANS ("GNP") whereby GNP would provide virtually the same range of medical care and related services and protections to enrollees, including enrollees such as GEORGE, which PACIFICARE was obligated to provide and in doing so, PACIFICARE purported to "pass on" or "lay off" to GNP the risk it assumed in entering into its agreement with GEORGE. Included among the services and protections which PACIFICARE, GNP and Does 1-15 agreed to afford to enrollees such as GEORGE was to provide the full range of health care benefits promised to GEORGE; not to deny or refuse to provide GEORGE with any such benefits without due notice including the reason for such denial and information on how to appeal any such denial; not to disenroll GEORGE or other enrollees except for very limited reasons such as GEORGE or other enrollees failing to pay their monthly premium or moving out of the geographic area served by PACIFICARE; and to provide quality care consistent with good medical practice to enrollees such as GEORGE. Notwithstanding such requirements, Defendants, and each of them, knowingly and intentionally failed to provide GEORGE with required notices, caused GEORGE to disenroll from PACIFICARE, and failed to take steps to ensure that enrollees such as GEORGE received quality care consistent with good medical practice.

9. Defendant GNP is a corporation doing business in Newport Beach, California. GNP is in the business of providing medical care to patients through its shareholders, officers, agents and employees who act as "primary care physicians" as well as "specialty

physicians." GNP has entered into an agreement with PACIFICARE to provide care to PACIFICARE enrollees, and was directed by PACIFICARE to render and direct medical care when caring for PACIFICARE enrollee patients including GEORGE, and was directed by PACIFICARE to comply with and carry out PACIFICARE's obligations to enrollees including GEORGE as required by PACIFICARE under the law.

10. Defendant LAKSHMI SHUKLA (hereinafter, "SHUKLA") is a physician doing business in Orange County. At all times mentioned, SHUKLA was Plaintiff GEORGE'S primary care physician or assigned pulmonologist, and upon information and belief, in the employ of, agent for, and an officer and director of GNP.

11. Plaintiffs are ignorant of the names and capacities of those Defendants sued herein as Does 1-15, inclusive, and for that reason has sued such defendants by such fictitious names.

12. Each of the defendants named herein are and were the agents, servants and employees of their co-defendants, and at all times mentioned were acting within the course and scope of such agency and employment, and pursuant to the policies, practices and procedures, written or otherwise, and with the approval and at the direction of their co-defendants.

13. At all times mentioned herein, Defendants SHUKLA, PACIFICARE, GNP, and Does 1-15, inclusive, in doing the things hereinafter alleged, agreed between them to override or disregard their duty to provide reasonably needed medical care to their patients, to provide the range of required protections to their patients, and to comply with their obligations under the law, solely in order to limit or reduce the cost of providing such care, and for the sake of profit. In doing the things hereinafter alleged, said defendants acted for their own benefit, and implemented and furthered their conspiracy and agreement, as aforesaid.

FIRST CAUSE OF ACTION
(Negligence by GEORGE v. PACIFICARE, GNP, SHUKLA and DOES 1-15)

14. GEORGE repeats and incorporates into this cause of action the allegations set forth above at paragraphs 1-12, inclusive.

15. After enrolling as a member of PACIFICARE and within 12 months prior to the filing of the Complaint in this action, GEORGE became ill, required and requested medical services from defendants SHUKLA, PACIFICARE, GNP, and Does 1-15, who thereupon owed GEORGE the duty to use ordinary skill and care in providing GEORGE with and rendering medical care and treatment to him and in providing GEORGE with all of the protections required of them pursuant to the law. Such duties owed by Defendants to GEORGE included, without limitation:

A. the duty to provide ready referrals consistent with good professional practice (Califomia Health & Safety Code Section 1367);

B. the duty to render medical decisions unhindered by fiscal and administrative management (Calif. Health & Safety Code Section 1367);

C. the duty to provide for expedited review and to notify GEORGE of his right to expedited review from DOC when Defendants' decisions involved imminent and serious threat to the health of GEORGE (Calif. Health & Safety Code Section 1368.01);

D. the duty to engage in sufficient quality assurance activities to ensure that the requirements of California law are met in providing services to GEORGE (Calif. Health & Safety Code Section 1370); and

E. the duty not to require GEORGE to disenroll except for very limited reasons such as nonpayment of

premiums (Calif. Health & Safety Code Section 1365). Such duties owed by Defendants to GEORGE also included, without limitation:

F. the duty of PACIFICARE to retain responsibility for all services including services which it contracts with others to provide GEORGE (42 C.F.R. Section 417.401);

G. the duty to ensure that required services are available and accessible to GEORGE (42 C.F.R. Section 417.416);

H. the duty to provide written notice of noncoverage including the reason for noncoverage and GEORGE's appeal rights before discharging GEORGE from hospital care (42 C.F.R. Section 417.440(f));

I. the duty not to disenroll GEORGE and not to encourage GEORGE to disenroll from PACIFICARE (42 C.F.R. Section 417.460(a)); and

J. the duty to provide grievance procedures for issues that do not involve organization determinations and Medicare appeal rights (42 C.F.R. Sections 417.600, 417.604 and 417.606).

16. Said defendants, and each of them, negligently, breached their aforesaid duty of care to GEORGE, and failed to secure for GEORGE the health care services he reasonably needed, including a lung transplant, failed to provide quality health care, failed to provide appropriate referrals with the result that needed health care was inaccessible to GEORGE, failed to provide legally required information to GEORGE, and negligently required and encouraged GEORGE to disenroll from PACIFICARE.

17. As a direct and proximate cause of the conduct of said Defendants, as aforesaid, GEORGE sustained personal injury which continues to date in a sum according to proof at trial.

18. As a further direct and proximate result of the conduct of the Defendants, as aforesaid, GEORGE has and will continue to incur medical expenses in a sum according to proof at trial.

SECOND CAUSE OF ACTION

(Willful misconduct by GEORGE v. PACIFICARE, GNP, SHUKLA and DOES 1-15)

19. GEORGE refers to the allegations set forth at paragraphs 1-13, inclusive, and 15, 17 and 18, as though set forth in full.

20. At all times mentioned herein, Defendants SHUKLA, PACIFICARE, GNP, and Does 1-15, knew that GEORGE was an enrollee with PACIFICARE, knew that GEORGE was their patient, and knew that GEORGE was in need of medical care including surgical assistance in order to treat a critical and progressive lung disease. Further, during this period said defendants knew that GEORGE's health continued to decline as a result of inadequate respiratory function. Said defendants and each of them knew that their failure to provide reasonably necessary care to GEORGE, their failure to take those steps necessary to treat GEORGE's condition, and their failure to provide GEORGE with the protections required under the law, would pose a serious and direct threat to GEORGE's life as well as his health. SHUKLA, PACIFICARE, GNP and Does 1-15 further knew that, as a result of their actions, GEORGE would continue to deteriorate, continue to suffer the debilitating and life threatening effects of his lung disease, including repeated episodes of pneumonia, emotional distress from fear of death, and would then experience an untimely death.

21. Said Defendants, and each of them, willfully, recklessly and intentionally breached their aforesaid duty of care to GEORGE. In particular, and without limiting the generality of the foregoing, said Defendants, and each of

them, failed to secure for GEORGE the health care services he reasonably needed, including a lung transplant, withheld quality health care, withhold appropriate referrals which rendered needed health care inaccessible to GEORGE, withhold legally required information from GEORGE, and encouraged and required GEORGE to disenroll from PACIFICARE. Said defendants failed and refused and continued to fail and to refuse to take the steps necessary to properly treat GEORGE's medical problems, to refer GEORGE to appropriate specialists, and to provide GEORGE with information as required by law for the purpose of allowing GEORGE to challenge their actions and inactions, because the cost to said Defendants of doing so posed an unacceptable drain on their financial resources and an unacceptable impediment to their plans for financial success in their business enterprise.

22. As a further direct and proximate result of the foregoing, GEORGE disenrolled from PACIFICARE and became a Medicare patient.

23. Because of his progressive and degenerative lung disease, GEORGE is totally disabled. He spends no more than 6-7 hours daily out of bed and even then is in a wheelchair, he is dependent upon a constant supply of oxygen, at night he is on a ventilator and receives food supplement through a gastric tube; he is unable to walk more than a few feet or stand for more than a minute or two without becoming oxygen deprived, and depends upon family for assistance with his activities of daily life. Accordingly, GEORGE is a "dependent adult" within the meaning of Penal Code § 368(e). By virtue of the foregoing, said defendants have acted in violation of California Penal Code § 368, and for this and other reasons, their conduct is despicable. Penal Code Section 368 provides, in part, that any person who has the care of an elder or dependent adult (such as GEORGE) and wilfully causes or permits the health of that person to be

injured or willfully causes or permits that person to be placed in a situation in which his or her health is endangered, is punishable by imprisonment in the county jail not exceeding one year, or in the state prison for two, three, or four years. Said defendants have acted with malice and oppression in that they have undertaken the care of GEORGE, a dependent adult, and consciously and intentionally violated GEORGE's right to receive reasonably necessary medical care, intentionally withheld appropriate referrals for an urgently needed lung transplant, intentionally forced GEORGE to disenroll from his health care provider, and consciously and intentionally disregarded his life as well as his health, all for the sole sake of minimizing their own costs and maximizing their own profits, and an award of punitive damages against said defendants (except those who prove to be "health care providers" per C.C.P. §304.5) in a sum according to proof at trial is justified, warranted and appropriate.

THIRD CAUSE OF ACTION
(Fraud—Count 1 by GEORGE v. PACIFICARE and Does 1-5)

24. GEORGE repeats and incorporates into this cause of action the allegations at paragraphs 1-13, inclusive, 15, 17-18, and 23.

25. In order to qualify as an insurer and provider of health care services to residents of the State of California including GEORGE, Defendants PACIFICARE and Does 1-5 made certain written representations and promises to the DOC, as part of their application for licensure as an HMO. Similarly, in order to qualify as an insurer and provider of health care services to Medicare beneficiaries, Defendants PACIFICARE and Does 1-5 made certain written representations and promises to the United States Department of Health and Human Services ("DHHS") as part of its contract with DHHS. As part of such written representations and promises

to such state and federal agencies, said Defendants represented and promised that care afforded to enrollees or members in their plans would meet certain minimum criteria and standards. In particular, and without limiting the generality of the foregoing, PACIFICARE and Does 1-5 promised and represented that the care and services offered to enrollees would meet the standards set forth in Paragraph 15, above, and that it was the intent of PACIFICARE and Does 1- 5 to offer services to enrollees which met said standards. Defendants PACIFICARE and DOES 1-5 also promised and represented that in marketing their health plan to potential enrollees and soliciting enrollees, that none of their representatives would be false, misleading or deceptive, as prohibited by California Health and Safety Code §1360, 42 USC §1395mm(c)(3)(C) and 42 CFR § 417.428. In addition, PACIFICARE and Does 1-5 promised and represented that the care and services offered to enrollees would comport with the representations made by PACIFICARE to enrollees to induce them to enroll as members with PACIFICARE and Does 1-5.

26. Said promises and representations were false when made and were known by said Defendants, their officers, directors and managing agents, to be false when uttered. In truth and in fact, said defendants knew that:

A. the care offered would not likely meet generally accepted professional standards;

B. the care offered would not likely include ready referrals consistent with good professional practice;

C. the medical decisions made on behalf of enrollees would not be unhindered by fiscal and administrative management;

D. they would not likely provide expedited review or notify an enrollee of the right to obtain expedited review from DOC if defendants' health care decisions

involved an imminent and serious threat to the enrollee's health;

E. they would not likely engage in sufficient quality assurance activities to ensure that the requirements of California law would be met in providing services to enrollees;

F. they would take steps to encourage members to disenroll when the cost of such members' health care needs exceeded the planned for or anticipated cost of an enrollee's care;

G. they would take steps to shift responsibility for all services away from PACIFICARE and Does 1-5 and onto other Defendants;

H. they would not likely make required services available and accessible to enrollees;

I. they would not likely provide written notice of noncoverage before discharging enrollees from hospital care;

J. they would not likely provide grievance procedures for enrollees for issues that do not involve Medicare organization determinations and Medicare appeal rights;

K. their insurance and care operations would not comport with the representations made by said defendants to induce enrollees to become members of defendants; and

L. they had no intention of complying with said promises and representations.

27. Said Defendants had a duty to refrain from making such representations and promises, as aforesaid, because they knew or should have known that such misrepresentations and promises presented a substantial and foreseeable risk of physical injury to a class of third persons which including

GEORGE, who would thereafter, because of the misrepresentations set forth above, enroll as a member of Defendants PACIFICARE and DOES 1-5, be denied care that comports with good medical practice, be deprived of information that would enable them to obtain timely and critically needed medical care, and a further substantial and foreseeable risk that persons including GEORGE would suffer permanent and serious harm to their lives as well as their health including harm of the sort experienced by GEORGE.

28. Said promises and representations were made for the purpose of securing a license or contract from DOC and DHHS as an HMO, and were intended by said Defendants to trick and deceive DOC and DHHS into approving PACIFICARE's and DOES 1-5's application to conduct business as an approved HMO and to enroll members such as GEORGE, which approval would not otherwise have been forthcoming. Said governmental agencies relied upon said representations and promises, and issued the aforesaid approvals, entered into contracts and issued licenses sought by said Defendants, thus enabling said Defendants to enter and remain in the HMO business.

29. As a result of the misrepresentations and promises as aforesaid, and as a further result of the issuance of a license to and the approval of a contract with said Defendants as aforesaid, GEORGE enrolled as a member of Defendants and, once enrolled, was denied referrals consistent with good medical practice and was denied life sustaining medical care unless and until he disenrolled from Defendants, simply because the cost of needed care was too high for Defendants to profit from GEORGE. As a direct and proximate result of the foregoing, GEORGE sustained physical, mental and emotional injury in a sum according to proof at trial.

30. By virtue of the foregoing, Defendants PACIFICARE and Does 1-5, inclusive, have acted in violation of Penal

Code §368, and for this reason and others, their conduct is despicable. Said defendants have acted with malice, fraud and oppression, and an award of punitive damages in a sum according to proof at trial against all defendants (except those who prove not to be "licensed health care providers" per C.C.P. §304.5) and according to the provisions of Civil Code §3345, is justified, warranted and appropriate.

FOURTH CAUSE OF ACTION

(Fraud - Count 2 by
GEORGE v. PACIFICARE and Does 1-5)

31. GEORGE repeats and incorporates into this cause of action the allegations at paragraphs 1-13, 15, 17-18, 23, and 30.

32. At the time that GEORGE enrolled as member of PACIFICARE, Defendants PACIFICARE and Does 1-5, inclusive, represented and promised in writing, in the marketing materials provided to GEORGE and others, that the care offered to GEORGE would include all of the benefits covered by Medicare, plus more, and afford GEORGE certain protections if he felt that the care was not of sufficient quality, and would comply with all of the requirements of state law. In addition, Defendants represented and promised in writing, in the marketing materials provided to GEORGE and others, that they were licensed by the State of California, that GEORGE could not be disenrolled from Defendants except for certain limited reasons such as failure to pay premiums, and that GEORGE would be provided an avenue to challenge Defendants on quality of care and other issues that are not subject to the Medicare appeals process.

33. Said representations and promises were, when made, false. The true facts were that although PACIFICARE was interested in obtaining persons who were entitled to Medicare benefits, including GEORGE, to enroll as

members, it had no intention of providing such care and protections to members if such care and protections could be avoided, or if the cost of that care was higher than levels which were established and adopted as part of goals for the financial performance of PACIFICARE's business operation, even if such care was reasonably appropriate or necessary for its patients in order for the care given to be consistent with good medical practice and even if such care and protections were required under the law.

34. Nonetheless, said representations and promises were made for the purpose of tricking and inducing George and others into enrolling as members of PACIFICARE and DOES 1-5.

35. GEORGE relied upon those representations and promises, and enrolled as a member of PACIFICARE and DOES 1-5.

FIFTH CAUSE OF ACTION

(Fraud - Count 3 by GEORGE v. GNP and DOES 6 -10)

36. GEORGE repeats and incorporates into this cause of action the allegations at paragraphs 1-13, 15, 17-18, 23 and 30.

37. In order to qualify as a provider of health services to persons enrolled as members of PACIFICARE, GNP and Does 6-10, made certain written representations and promises to PACIFICARE, some of which are contained in its provider agreement with PACIFICARE, that care afforded participants or members in PACIFICARE would meet specified criteria and standards, including without limitation the criteria and standards imposed under California HMO law and including the protections afforded HMO enrollees under federal Medicare law. In particular and without limiting the generality of the foregoing, GNP and Does 6-10 represented to PACIFICARE and promised that the care offered by them

would meet the criteria and standards specified in paragraph 15, above, and further, that GNP intended to comply with its requirements.

38. Said promises and representations, when made, were false and, when uttered by GNP and its officers, directors and managing agents, and Does 6-10, were known to be false. In truth and in fact, GNP and Does 6-10, knew that:

A. the care offered would not likely meet generally accepted professional standards if the cost of that care would be too high for GNP and DOES 6-10 to profit;

B. the care offered would not likely include ready referrals consistent with good professional practice if the cost of such referrals would be too high for GNP and DOES 6-10 to profit;

C. the medical decisions made on behalf of enrollees would not be unhindered by fiscal and administrative management;

D. they would not likely provide expedited review or notify an enrollee of the right to obtain expedited review from DOC if defendants' health care decisions involved an imminent and serious threat to the enrollee's health;

E. they would not likely engage in sufficient quality assurance activities to ensure that the requirements of California would be met in providing services to enrollees;

F. they would take steps to encourage members to disenroll when the cost of such members' health care needs exceeded the planned for or anticipated cost of an enrollee's care;

G. they would not likely make required services available and accessible to enrollees if the cost of such services would be too high for GNP and DOES 6-10 to profit;

H. they would not likely provide written notice of noncoverage before discharging enrollees from hospital care;

I. they would not likely provide grievance procedures for enrollees for issues that do not involve Medicare organization determinations and Medicare appeal rights;

J. their operations would not comport with the representations made by said defendants to induce PACIFICARE and DOES 1-5 to contract with them and to induce PACIFICARE enrollees to become their patients; and

K. said defendants did not intend to abide by their promises.

39. Defendants GNP and Does 6-10, inclusive, had a duty to refrain from making such representations and promises, as aforesaid, because they knew or should have known that such misrepresentations and promises presented a substantial and foreseeable risk of physical injury and even death to third persons, including GEORGE, who would enroll in an PACIFICARE plan and who would be referred to GNP and Does 6-10, or who would select GNP and Does 6-10 as care providers, and that personal injury of the sort experienced by GEORGE would result from said misrepresentations.

40. Said promises and representations were made for the purpose of securing the execution by PACIFICARE of an agreement which would provide potentially lucrative payments to GNP and Does 6-10 by PACIFICARE in return for health care services to be provided by GNP and DOES 6-10 to PACIFICARE plan enrollees, and were intended by said Defendants to trick and deceive PACIFICARE into approving and accepting said offer of GNP and DOES 6-10 to provide health care services to PACIFICARE's enrollees. In reliance upon said promises and representations,

PACIFICARE selected GNP and DOES 6-10 to act as PACIFICARE approved primary care physicians for the benefit of plan enrollees including GEORGE.

SIXTH CAUSE OF ACTION

(Constructive Fraud by
GEORGE v. SHUKLA, PACIFICARE,
GNP and Does 1-15)

41. Plaintiff repeats the allegations at paragraphs 1-13, inclusive, 15, 17-18, 23 and 30.

42. As a patient of defendants SHUKLA, PACIFICARE, GNP and Does 1-15, GEORGE trusted and confided in said defendants in all matters related to his health, his medical care and condition; and said defendants accepted said trust and confidence. Accordingly, GEORGE was owed a fiduciary duty by SHUKLA, PACIFICARE, GNP and Does 1-15, inclusive, with regard to matters of his health, his medical care and condition. This relationship required, among other things, that said defendants place GEORGE's interests in receiving fair and reasonable medical treatment (including uncompromised decisions for testing, diagnosis, and treatment of GEORGE) in a position paramount to their own interests, and that GEORGE receive full and fair disclosure of information concerning said defendants' financial and other conflicting interests in denying GEORGE such fair treatment.

43. Said defendants breached the aforesaid fiduciary duty as follows:

A. said defendants failed to follow standard medical practice requiring that GEORGE's medical condition be properly treated, because to do so would have reduced net income to said defendants, in a sum equal to the cost of securing proper medical treatment for GEORGE;

B. Said defendants failed to disclose to GEORGE that they had a financial interest regarding GEORGE's

care which was adverse to GEORGE (and to his interest in receiving reasonably necessary medical care for his illnesses and diseases) in that said defendants had failed to take steps to insulate medical decision making from fiscal and administrative concerns even though they were in a business which profited from the denial of reasonably necessary medical care to GEORGE, while at the same time said defendants purported to offer GEORGE objective and complete medical advice, care, and treatment concerning his deteriorating health condition; and

C. said defendants failed to disclose to GEORGE that they had conflicting fiduciary duties and interests, in part as to SHUKLA and DOES 11-15, by virtue of their status as both an agent and fiduciary of PACIFICARE and DOES 1-5 and of GNP and DOES 6-10, simultaneously, and of GEORGE.

44. As a direct and proximate result of the breaches, as aforesaid, GEORGE received improper and inadequate medical care from said Defendants, to his physical, mental and emotional suffering, as aforesaid, and pecuniary loss in a sum according to proof at trial. As a further direct and proximate result of said breaches, GEORGE was ignorant that the advice, treatment, diagnosis and care he received was influenced by said defendants' financial interest, and accordingly, was misled as he relied upon said advice and treatment.

45. Said defendants' conduct subjected GEORGE to a serious risk that his health and safety would be endangered, as needed medical care and assistance was withheld from GEORGE while GEORGE was ignorant of said defendants' conflict of interest, and while he continued, in ignorance to rely upon such advice. In doing so, Defendants and each of them were motivated to place their own financial interests

paramount to their duties to GEORGE to provide proper and reasonably necessary health care services.

SEVENTH CAUSE OF ACTION

(Intentional Infliction of Emotional Distress by GEORGE v. PACIFICARE, SHUKLA, GNP, and Does 1-15)

46. Plaintiff repeats and incorporates into this cause of action the allegations at paragraphs 1-13, inclusive, 15, 17-18, 23 and 30.

47. Defendants' conduct, as aforesaid, was outrageous. At the time said conduct was occurring, GEORGE had been suffering from a serious life threatening progressive lung disease, which resulted in a series of admissions to an acute care hospital to treat pneumonia-like conditions, caused him to lose weight so that GEORGE lost approximately one-third of his body weight, caused him to endure months and years of unremitting pain and discomfort, an inability to sleep properly, an inability to take part in the regular activities to which he was accustomed for a period of many months, a total dependence upon bottled oxygen, ventilators, tracheotomy and intubation, and was subjected to and experienced feelings of unremitting illness, helplessness and mortality. Although GEORGE was obviously ill and near death and Defendants were aware of this fact, and although GEORGE needed a lung transplant, without which he would die, and Defendants were aware of this fact as well, rather than afford him surgical intervention needed to save his life, they elected a much less expensive course of treatment, for the sole sake of limiting the cost of his medical care, and without providing legally required information to GEORGE regarding his rights to challenge such actions and conduct.

48. As a direct and proximate result of the foregoing, GEORGE sustained severe emotional distress, general

damages for his personal injury, and pecuniary damages for the cost of his medical care.

EIGHTH CAUSE OF ACTION
(Negligent Infliction of Emotional Distress
by BARBARA v. PACIFICARE, GNP and Does 1-10)

49. BARBARA repeats the allegations set forth above at paragraphs 1-13, inclusive.

50. BARBARA regularly visited GEORGE during the extended periods of time when he was admitted to various medical facilities ostensibly for diagnosis and treatment of his conditions within the 12 months prior to the filing of this action. During said visits and at all other times, BARBARA was aware that GEORGE was suffering, in pain, losing weight and that his health was failing.

51. During said visits and at all other times, BARBARA consulted continuously and closely with Defendants regarding GEORGE's condition and treatment options. Defendants failed to provide or even offer appropriate treatment options and, when questioned directly by Plaintiffs about treatment options including a lung transplant, Defendants acknowledged that they were aware a lung transplant could save GEORGE's life but nevertheless refused to provide appropriate treatment options or appropriate referrals as needed by GEORGE and consistent with good medical practice unless and until GEORGE disenrolled from PACIFICARE and DOES 1-5 and failed to make any kind of grievance or expedited grievance procedure available to GEORGE. BARBARA was a participant in or witness to such failure and refusal to provide needed care, such communications, and such failures to provide information that Defendants' actions and failure to provide care could be challenged.

52. BARBARA needlessly suffered feelings of grief, anger, depression and helplessness as Defendants and each of them repeatedly failed and refused to offer appropriate treatment to GEORGE, to refer GEORGE to specialists consistent with good medical practice, or to treat GEORGE, unless and until he disenrolled from PACIFICARE and DOES 1-5; repeatedly failed to explain that they had an adverse financial interest in the health care decisions they were making with respect to GEORGE; and repeatedly failed to give legally required information to enable Plaintiffs to file a grievance or request expedited review from the State of California DOC with respect to the quality of care and improper disenrollment by Defendants.

53. In doing the things hereinabove alleged, Defendants, and each of them, knew or should have known that as a result of the foregoing conduct, which was outrageous, it was foreseeable that BARBARA would suffer severe emotional distress.

54. As a direct and proximate result of the foregoing, BARBARA has sustained severe emotional distress to her damage in a sum according to proof at trial.

NINTH CAUSE OF ACTION

(Unfair Business Practices per Bus. & Prof. Code §17200 by George v. PACIFICARE and Does 1- 5)

55. GEORGE repeats the allegations set forth above at paragraphs 1-13, inclusive, 15-18, inclusive, 20-23, inclusive, 25-30, inclusive, 32-35, inclusive, and 37-40, inclusive, 42-45, inclusive, and 47-48, inclusive.

56. In the course of Defendants' conduct, as aforesaid, Defendants have violated a number of laws, including breaches of so-called state "common law" duties, statutes prohibiting conduct such as PACIFICARE's, GNP's and SHUKLA's, statutes prescribing penal consequences for such

conduct, and statutes and regulations governing the operation of HMOs as set forth in paragraphs 15, above. Accordingly, Defendants have engaged in unfair and fraudulent business acts and practices as set forth in Bus. & Prof. Code § 17200.

57. Accordingly, this court should issue an injunction prohibiting Defendants and each of them from engaging in such unfair and fraudulent business acts and practices, as particularly set forth in Plaintiff's prayer for relief herein.

WHEREFORE, Plaintiffs pray judgment as follows:

On the 1st, 2nd, 3rd, 4th, 5th, 6th, 7th and 8th causes of action:

1. For general and special compensatory damages in a sum according to proof and in excess of the maximum jurisdiction of the municipal court.

2. For punitive damages according to proof, and in the case of the 3rd, 4th and 5th causes of action, that said punitive damages be trebled.

On the 9th cause of action:

3. For a permanent injunction prohibiting Defendants from refusing to offer services required by law to be available to their enrollees.

4. For a further permanent injunction prohibiting Defendants from refusing to offer reasonably necessary and appropriate care to enrollees.

5. For a further permanent injunction prohibiting Defendants from failing to provide required notice of denials of care including the reasons for such denial and how to file an appeal or grievance regarding such denial.

6. For a further permanent injunction prohibiting Defendants from failing to provide expedited grievance proceedings and from failing to provide enrollees information on their right to obtain an expedited review from the State of California Department of Corporations.

7. For a further permanent injunction prohibiting Defendants from engaging in business as a health care services plan in the State of California until said Defendants satisfy the court that said defendants do not employ policies, practices, formulate or implement job performance criteria or incentives, the effect of which is to unduly influence decisions to provide or withhold reasonably necessary medical care or treatment based on financial and administrative considerations, and that said defendants are not organized in a manner which allows persons whose responsibilities include making and implementing care or treatment decisions to be unduly influenced by financial or administrative concerns.

8. For a further permanent injunction prohibiting defendants from entering into agreements with groups of health care providers to provide health care and services to HMO enrollees when such agreements reserve, either expressly, implicitly or by operation, to the HMO the power to withhold, based on fiscal and administrative concerns, care and treatment deemed reasonably necessary or appropriate by a recipient's primary care physician.

On all causes of action:

9. For costs of suit, and in the case of the 3rd, 4th and 5th causes of action for prejudgment interest on all sums awarded as compensatory damages per CCP §3288;

10. For attorneys' fees per Welf. & Inst. Code §15657 on all causes of action, except the 8th cause of action; and in the case of the 9th cause of action for attorneys fees per Bus. & Prof. Code §§ 17200, et seq.; and

11. For such other and further relief as the court deems just and proper.

HOUCK & BALISOK
-and-
CAROL S. JIMENEZ

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No. 01-199

In The

Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC., and
GREATER NEWPORT PHYSICIANS, INC.,

Petitioners,

v.

BARBARA MCCALL,
Individually and as Trustee, etc.,

Respondent.

On Petition For A Writ Of Certiorari To The Supreme Court Of California

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QUESTION PRESENTED

Whether state law claims against a Medicare-subsidized HMO, which is required under the Medicare Act (42 U.S.C. § 1395mm(b)) to operate under state law, that are outside the scope of the Medicare administrative process fall within Medicare's exclusive administrative review provisions.

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RESPONDENT'S BRIEF IN OPPOSITION

Respondent Barbara McCall respectfully requests that this Court deny the petition for writ of certiorari. The petition seeks review of the opinion of the California Supreme Court affirming reversal of the trial court's order, which sustained Petitioners' demurrers to the complaint without leave to amend.

OPINIONS BELOW

The opinion of the Supreme Court of California is published at 25 Cal.4th 425 (2001) and the opinion of the Court of Appeal of the State of California, Fourth Appellate District, is published at 74 Cal.App.4th 257 (1999).

STATUTORY PROVISIONS INVOLVED

Petitioners set forth two of the statutory provisions, 42 U.S.C. §§ 405(g) and 405(h), relevant to the opinion below. In addition, the following statutory provision is critical to the analysis of the issues underlying the Petition.

42 U.S.C. § 1395mm(b)[1] sets forth the requirements that HMOs must meet in order to provide care to Medicare beneficiaries, providing in pertinent part that:

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[1] As noted by the California Supreme Court, subsequent to the events in this case, Congress enacted a new part of Medicare called "Medicare + Choice" (Pub.L. No. 105-33 (Aug. 5, 1997) 111 Stat. 328, codified at 42 U.S.C. §§ 1395w-21 *et seq.*). Effective January 1, 1999, this new law applies to HMOs such as PacifiCare, instead of the law at issue in this case. App. 14a.

> For purposes of this section, the term 'eligible organization' means a public or private entity (which may be a health maintenance organization or a competitive medical plan) *organized under the laws of any State* . . .

(Emphasis supplied.)

STATEMENT OF THE CASE

George McCall, the now deceased husband of respondent Barbara McCall, enrolled in the HMO operated by petitioners PacifiCare of California, Inc. and PacifiCare Health Systems, Inc. (jointly "PacifiCare"), which was paid a flat monthly fee by Medicare to care for George no matter how much care he needed. As required by Medicare law and by state law, PacifiCare was licensed by the State of California and was required to operate under the provisions of California law. Petitioner Greater Newport Physicians, Inc. ("GNP") was the medical group that PacifiCare arranged to help it provide medical care to George.

In 1997, George became extremely ill due to progressive lung disease. Neither PacifiCare nor GNP denied George coverage of a particular service. Rather, PacifiCare and GNP refused to care for George altogether and intentionally withheld information from George about available treatment options, knowing that their actions would cause George's health to continue to deteriorate, would cause George to continue to suffer the debilitating and life-threatening effects of his progressive lung disease, and would likely cause George's untimely death.

When McCall learned about available treatment options from another source and asked PacfiCare and GNP about them, PacifiCare and GNP forced George to disenroll from PacifiCare in order to obtain them. Petitioners forced George to disenroll from PacifiCare for no reason other than to save themselves money, as once George was disenrolled from PacifiCare, the Medicare program and not Petitioners would pay the cost of George's care.

McCall brought this action in state court in 1997. McCall alleges eight causes of action for tort damages based on claims of negligence, wilful misconduct, four counts of fraud including fraudulent misrepresentation and constructive fraud, and intentional and negligent infliction of emotional distress, as well as a ninth cause of action for injunctive relief from unfair business practices, all under state law. As part of the state law causes of action, McCall alleges violation of a wide range of state law requirements and also alleges violation of selected provisions of Medicare law that are unrelated to benefits determinations, such as the duty not to encourage George to disenroll from PacifiCare. McCall does not seek any Medicare covered benefit, either directly or indirectly.

Petitioners' description of the allegations in this case is simply wrong. For example, Petitioners' "critical point" (at p. 5) that "Each count [of Respondent's complaint] was based on alleged violations of duties under the Medicare Act, most notably the duty to provide coverage for a lung transplant at UCSD" embellishes the complaint and the opinion below with allegations and statements that

are nowhere to be found.[2] McCall's claims do not rest on petitioners' alleged violations of duties under the Medicare Act. *See, e.g.*, App. 76a, 79a, 82a, 88a-89a.

PacifiCare and GNP demurred to the First Amended Complaint on the ground that all of McCall's claims are preempted by federal Medicare law. The trial court sustained PacifiCare's and GNP's demurrers without leave to amend, and entered judgment in their favor. The appellate court reversed the trial court's judgment.

The California Supreme Court granted review on the sole question of whether state law claims against a Medicare-subsidized HMO fall within Medicare's exclusive review provisions. The California Supreme Court concluded that none of the claims presented by McCall fall within Medicare's exclusive review provisions, stating that "[a] Medicare provider may violate state common law or statutory duties owing to beneficiaries, unrelated to its Medicare coverage determinations." App. 16a. In reaching this conclusion, the court carefully reviewed the allegations and elements of each cause of action in the complaint (App. 2a-3a,16a-18a), the language and legislative history of the Medicare Act (App. 12a-13a), the case

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[2] Petitioners' footnotes also misstate this case. For example, the allegations they offer in footnote 3 (at p. 3) are nowhere to be found in the complaint. The unsigned, uncertified excerpt from Volume 3 of the Deposition of George McCall is not part of the record, was not considered by any of the courts below, and may not be considered on demurrer, the motion at issue in the court below. See *Alcorn v. Anbro Engineering, Inc.*, 2 Cal.3d 493, 496 (1970). Similarly, footnote 4 (at p. 4) contains "facts" that are not part of the record, not found in App. 2a, footnote 1, which it cites as support, and are in fact incorrect.

law interpreting the Medicare Act including the cases relied on by Petitioners (App. 5a-10a, 19a), and HCFA's[3] explicit analysis and interpretation of the Medicare Act as it relates to the question presented (App. 14a-15a).

Petitioners wrongly identify (at p. 7) as the California Supreme Court's holding in the *McCall* case, the court's discussion of the holding and rationale in a California Court of Appeal case, *Redmond v. Secure Horizons, Pacificare, Inc.*, 60 Cal.App.4th 96 (1997). App. 12a. The California Supreme Court did *not* hold, as Petitioners assert, that "the McCalls' claims did not arise under the Medicare Act, even though they were premised on the alleged violations of duties under that Act. . . . " To the contrary, the court found that the claims presented by McCall were *not based* on the HMO's alleged failure to provide Medicare covered benefits. App. 16a-18a. Petitioners also erroneously imply (at p. 2) that allegations that are unrelated to benefits determinations should nevertheless proceed through the Medicare administrative appeals process, even though such allegations are clearly outside its scope. See App. 15a; 42 C.F.R. §§ 417.600, 417.604, 417.606. The California Supreme Court found that none of McCall's claims requires a Medicare coverage determination, none seeks at bottom payment or reimbursement of a Medicare claim, none falls within the Medicare administrative

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[3] HCFA stands for the Health Care Financing Administration, which until recently was the name of the federal agency charged with administering the Medicare program. Since Petitioners refer to the federal agency as HCFA rather than by its current name, Center for Medicare and Medicaid Services, Respondent will do the same.

review process, and none is remediable through the Medicare administrative review process. App. 18a-19a.

By the opinion below, the Supreme Court of California has ordered that the judgment against McCall be reversed and that Petitioners' demurrers be overruled. This case may now proceed to trial and there is no way to predict whether McCall will prevail on any of the claims against PacifiCare and GNP.

REASONS FOR DENYING THE PETITION

Review is unwarranted for three reasons. First, a proper jurisdictional basis is lacking because the state court decision below is not a "final judgment" within the meaning of 28 U.S.C. § 1257. *Jefferson v. City of Tarrant*, 522 U.S. 75 (1997); *Flynt v. Ohio*, 451 U.S. 619, 622 (1981). Second, there is no conflict among the federal circuit courts or state high courts of last resort regarding the question presented here. Third, the decision below is correct.

I. THIS COURT LACKS JURISDICTION TO REVIEW THE NON-FINAL DECISION BELOW.

"This case, still *sub judice* in [California], was brought to this Court too soon." *Jefferson v. City of Tarrant*, 522 U.S. at 77. This Court's review of state-court decisions is limited to "[f]inal judgments or decrees rendered by the highest court of a State in which a decision could be had." 28 U.S.C. § 1257(a). Here, the ruling of the California Supreme Court affirms the appellate court's ruling

reversing the trial court's judgment against McCall. The case has now been remanded for further proceedings and may now proceed to trial. App. 1-5. Thus, the decision below does not qualify as a "final judgment" within the meaning of Section 1257.

This Court has identified four categories of cases that constitute exceptions to the finality requirement of Section 1257. *Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 477-87 (1975). As to the first three, this Court recognizes exceptions where (1) "the federal issue is conclusive or the outcome of further proceedings preordained," (2) the federal issue "will survive and require decision regardless of the outcome of further state court proceedings," and (3) "later review of the federal issue cannot be had, whatever the ultimate outcome of the case." *Id.* at 479-81; *see also Jefferson v. City of Tarrant*, 522 U.S. at 82. As to these three categories, the judgment involved here does not even arguably apply. If Petitioners prevail on remand, the question presented will no longer require decision. Thus, as in *Jefferson v. City of Tarrant*, "[t]he outcome of those further proceedings could moot the federal question" presented here. 522 U.S. at 77. On the other hand, if Petitioners do not prevail on remand, they "will be free to seek [Supreme Court] review when the state-court proceedings reach an end." *Id.*

The fourth exception has two requirements. First, the state court judgment must represent the final word within the state court system on a federal issue, "with further proceedings pending in which the party seeking review here might prevail on the merits on nonfederal grounds, thus rendering unnecessary review of the federal issue by this Court, and where reversal of the state

court on the federal issue would be preclusive of any further litigation on the relevant cause of action." In addition, "a refusal immediately to review the state-court decision" must present a risk of "seriously erod[ing] federal policy." *Cox Broadcasting*, 420 U.S. at 482-83.

This category is also inapplicable here. Allowing this case to proceed to final judgment, rather than immediately reviewing the decision below, does not risk "seriously erod[ing]" any federal policy. Petitioners are required by Medicare law to operate under the laws of the State of California and, as discussed *infra*, the opinion below has no impact on the Medicare program. *Cf. Southland Corp. v. Keating*, 465 U.S. 1, 6-8 (1984) (allowing adjudication of dispute where parties had contracted for arbitration might erode federal policy embodied in Federal Arbitration Act); *Belknap v. Hale*, 463 U.S. 491, 497 n.5 (1983) (allowing case to go forward would risk eroding federal policy requiring matter at issue to be decided by NLRB, not by state courts); *Cox Broadcasting*, 420 U.S. at 485-87 (delaying review would leave important question regarding freedom of press in "uneasy and unsettled constitutional posture [that] could only further harm the operation of a free press"). Therefore, this case does not satisfy the requirements of the fourth exception.

Since this case may now proceed to trial, there has been no "final judgment" within the meaning of Section 1257. Thus, Supreme Court jurisdiction is lacking.

II. NO CONFLICT EXISTS AMONG ANY FEDERAL CIRCUIT COURTS OR STATE HIGH COURTS ON THE QUESTION PRESENTED.

Six different federal courts have published opinions directly on point with the issue raised by Petitioners. Without exception, each of these courts has found that state law claims, including those seeking tort remedies based upon failure to provide Medicare covered services, may be asserted against an HMO or other health care provider as they do not arise under the Medicare Act. *Ardary, et al. v. Aetna Health Plans of California, Inc., et al.*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251 (1997); *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997); *Plocica v. Nylcare of Texas, Inc.*, 43 F.Supp.2d 658 (N.D. Tex. 1999); *Winkler v. Interim Services, Inc.*, 36 F.Supp.2d 658 (M.D. Tenn. 1999); *Zamora-Quezada, et al. v. HealthTexas, et al.*, 34 F.Supp.2d 433 (W.D. Tex. 1998); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998).

Whether state law claims must go through the Medicare administrative review process was addressed in *Ardary v. Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251 (1997). In *Ardary*, Justice O'Scannlain explained that the Ninth Circuit could find nothing in either the language or the legislative history of the Medicare Act that suggested Congressional intent to abolish all state remedies for torts committed by a Medicare provider. Although the complaint in *Ardary* did not seek recovery of Medicare benefits, it was undisputed that all of the claims were predicated on the allegation that a Medicare covered benefit had been wrongfully denied. (*Ardary v. Aetna*, 98

F.3d at 498.) Applying *Heckler v. Ringer*, 466 U.S. 602 (1984), and *Weinberger v. Salfi*, 422 U.S. 749 (1975), the Ninth Circuit found that the standing for the six tort claims was state common law theories and not the Medicare Act.

In *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997), a Medicare beneficiary challenging discharge from a nursing home alleged violations of Medicare law regarding residents' rights including laws governing discharge and quality of care. The Fourth Circuit found that the Medicare administrative review process did not encompass all of plaintiff's claims and did not afford the relief sought by plaintiff. Since plaintiff's claims were not for benefits under the Medicare Act, but rather for damages resulting from violation of certain of its provisions, Medicare's exhaustion of administrative remedies requirement did not apply. *See also Alacare, Inc.-North v. Baggiano*, 785 F.2d 963 (4th Cir. 1997) (The Eleventh Circuit reached a similar conclusion with respect to claims by a Medicaid patient); *Plocica v. Nylcare of Texas, Inc., et al.*, 43 F.Supp.2d 658 (N.D. Tex. 1999) (The Medicare Act does not preempt common law claims against a Medicare HMO for alleged inadequate quality of care and treatment); *Winkler v. Interim Services, Inc.*, 36 F.Supp.2d 1026 (M.D. Tenn. 1999) (Tort and other claims by Medicare beneficiaries against a Medicare provider for failure to provide medically necessary care because of cost considerations are not preempted by 42 U.S.C. §§ 405(g) and (h) because they do not seek anything of the Secretary or the U.S. government); *Zamora-Quezada, et al. v. HealthTexas, et al.*, 34 F.Supp.2d 433 (W.D. Tex. 1998) (Medicare's exhaustion of administrative remedies requirement does not

apply to claims by beneficiaries against their HMOs alleging state law causes of action as well as violations of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F.Supp.2d 273 (E.D.N.Y. 1998) (state law tort claims against a Medicare HMO that are related to services under Medicare but do not seek to recover Medicare benefits are wholly collateral to a claim for benefits and thus are not preempted by Medicare).

Petitioners fail to apprise (at pp. 11, 18-19) this Court of the numerous federal cases directly on point with the present case (and cited by both the California Supreme Court and the Court of Appeal in their decisions (App. 8a-9a, 45a-47a)) and that the opinion below is in conformity with every published federal court opinion regarding the question presented here.

Instead of discussing the case law directly on point, Petitioners focus on federal court cases that have been brought by medical providers against the Secretary of DHHS (or her fiscal intermediaries, whose sole role is to process claims for payment by the Secretary) and have involved an issue of claims processing or termination of their own contract with the Secretary. See Petition at pp. 11, 14, 16-18, citing *Bodimetric Health Services, Inc. v. Aetna Life and Casualty*, 903 F.2d 480 (7th Cir. 1990), *Midland Psychiatric Associates, Inc. v. United States*, 145 F.3d 1000 (8th Cir. 1998), and *Affiliated Professional Home Health Care Agency v. Shalala*, 164 F.3d 282 (5th Cir. 1999). The present case is not brought by a provider against the government, but rather is brought by a patient against those making treatment decisions, and the present case does not involve claims processing or federal funds. By focusing

on inapposite cases, Petitioners claim a conflict between the decision of the California Supreme Court and the federal courts that simply does not exist.

III. THE DECISION BELOW IS CORRECT.

An examination of the Medicare Act itself, its legislative history and HCFA's interpretation of it underscores the correctness of the opinion below. As the court below noted, *the Medicare Act explicitly requires HMOs to operate under state law* (42 U.S.C. § 1395mm(b))[4] and prohibits any federal officer or employee from exercising any supervision or control over the manner in which medical services are provided or over any institution providing health services (42 U.S.C. § 1395). App. 13a-14a. Nothing in the legislative history of the Medicare Act indicates that Congress intended to obliterate state laws governing Medicare-subsidized HMOs including state tort remedies. See *Ardary v. Aetna*, 98 F.3d at 501-502; App. 12a-14a. The court below also reviewed HCFA's interpretation of the law, which plainly states that tort and other state law claims against an HMO are not preempted, even if such claims also involve Medicare coverage determinations. App. 14a-15a, citing 63 Fed. Reg. 34967, 35012, 35013

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[4] In contrast to the Medicare Act which is at issue here, the express language of a different federal statutory scheme, the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*, governing employee benefit plans including health insurance, does preempt state tort law. ERISA specifically provides that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a); App. 13a.

(June 26, 1998). *See also U.S. v. Mead Corp.*, ___ U.S. ___, 121 S.Ct. 2164 (2001) (In a program for which Congress has delegated rule making authority, courts should accord great deference to interpretations promulgated pursuant to the Administrative Procedure Act by the implementing administrative agency); *Chevron USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). HCFA's view makes sense in light of the fact that Medicare beneficiaries who receive medical care in the fee-for-service system can bring state tort claims against medical providers for bad care and treatment decisions. There is nothing legally or logically different about Medicare beneficiaries who receive medical care from HMOs bringing state tort claims against their HMOs and other medical providers for bad care and treatment decisions.

The correctness of the decision below is also highlighted by the disparity between how the Medicare Act treats fiscal intermediaries and carriers (jointly referred to herein as "intermediaries"), on the one hand, and HMOs, on the other hand. Intermediaries are insurance companies with which Medicare contracts to process fee-for-service claims on behalf of the Secretary. 42 U.S.C. § 1395h(i). The Secretary and intermediaries neither provide nor arrange for medical care; they simply make after the fact determinations as to payment. Intermediaries determine claims for payment and then pay allowed claims using federal funds, not their own funds. 42 U.S.C. §§ 1395h (Part A claims) and 1395u (Part B claims). The Secretary provides the intermediaries the funds to pay claims and simply pays the intermediaries an administrative fee for performing this function. *Id.* The Secretary,

and not intermediaries, is liable for any payments certified by intermediaries for payment. 42 U.S.C. §§ 1395h(i) (fiscal intermediaries) and 1395u(e) (carriers).

In contrast, HMOs that serve Medicare beneficiaries do not simply pay claims for services already rendered; they actually provide or arrange for care. 42 U.S.C. § 1395mm(c)(4); 42 C.F.R. §§ 417.401, 417.414, 417.416. The Medicare program pays such HMOs a flat amount per month per enrollee, regardless of the frequency, extent or kind of health services actually provided to, paid for, or needed by a member. 42 U.S.C. §§ 1395mm(a)(1), (a)(4), (b)(1). The HMO, and not the Medicare program, is liable for any care needed by a member and for any payments to be made for a member's care (42 U.S.C. §§ 1395mm(b), (g)(6)), and the HMO profits from any remaining balance. The monthly amount the Medicare program pays an HMO is completely unaffected by any HMO administrative costs or by the HMO's liability for claims or tort damages. *Id.*

In addition, only limited types of claims, called "organization determinations," may be funneled through the administrative review process. All other types of claims are considered to be "grievances" and are specifically excluded from administrative review. 42 U.S.C. § 1395mm(c)(5); 42 C.F.R. §§ 417.600, 417.604(a), 417.606. Included in the broad category of grievances are issues regarding marketing problems, quality of care and involuntary disenrollment. *Id.; see also* 42 C.F.R. §§ 417.428(b)(2), 417.460(a). Thus, by definition, as noted by the court below (App. 15a-18a), McCall's claims are outside the scope of Medicare's administrative review.

The decision of the court below is based on the language of the Medicare Act, its legislative history, the uniformly consistent case law regarding the issue presented here, and the distinguishable case law involving claims against intermediaries and carriers which has been offered by Petitioners. The opinion of the court below is correct.

IV. THE IMPACT OF THE DECISION BELOW IS LIMITED.

A. The Decision Below Is Limited in Scope.

Petitioners argue (at p. 25) that this case opens the door for Medicare beneficiaries, and even Social Security recipients, nationwide to sue Medicare carriers and intermediaries when their benefit claims are denied. As discussed above, this case brings California into conformity with the federal courts. The impact of this case is limited to California Medicare beneficiaries who have claims against their HMOs that do not fall within the scope of the Medicare administrative review process. App. 1a. Moreover, as noted by the California Supreme Court, its decision is based upon the law prior to the Balanced Budget Act of 1997 (Pub.L. No. 105-33 (Aug. 5, 1997) 111 Stat. 328, codified at 42 U.S.C. §§ 1395w-21 *et seq.*), which governs Medicare HMOs including PacifiCare effective January 1, 1999. App. 14a-15a. Thus, the impact of this case may be limited in time as well.

B. The Decision Below Does Not Impact the Operation or Finances of the Medicare Program or Federal Treasury.

Petitioners also suggest (at pp. 26-28) that the decision below will increase the costs of administering the Medicare program, will divert scarce federal resources to state court litigation, and will have a dramatic impact on federal funding of Medicare. Petitioners cite no authority for such propositions because none exists. Petitioners erroneously portray the way the Medicare program operates and the way the Medicare program pays HMOs.

As stated above, the Secretary pays HMOs a predetermined flat amount per month per enrollee, regardless of the frequency, extent or kind of health services actually provided to or paid for a member's care. 42 U.S.C. §§ 1395mm(a)(1), (b)(1). HMOs actually provide or arrange for care, and the Medicare program's cost or liabilities are not affected by the amount of care needed by the HMO's Medicare members or by the amount of claims against the HMO. 42 U.S.C. § 1395mm(c)(4). The Medicare program has no liability for the HMO's obligations. 42 U.S.C. §§ 1395mm(a)(1), (b)(1), (c)(4). In fact, if the Medicare program pays any amount that should have been paid by the HMO, the Medicare program may recoup such amounts from the HMO. 42 U.S.C. § 1395mm(g)(6). The funds for enrollees' medical care and for paying enrollees' claims come directly out of Petitioners' proverbial pocket and Petitioners profit by any monies not spent on enrollees' care. The particular type of care or claim that might be at issue has no impact on federal funds.

CONCLUSION

Petitioners' petition for a writ of certiorari should be denied.

Respectfully submitted,

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No. S082236

IN THE SUPREME COURT OF CALIFORNIA

REMITTITUR

TO THE Court of Appeal,
Fourth Appellate District, Division Three

BARBARA McCALL, Individually and as Trustee, etc.,	S082236 Ct. App. #G024030 Orange County Superior Court – Main Super. Ct. No. 788545
Plaintiff and Appellants,	
v.	
PACIFICARE, et al.,	
Respondents.	

I, FREDERICK K. OHLRICH, Clerk of the Supreme Court of the State of California, do hereby certify that the attached are copies of the original judgment now final entered in the above-entitled cause on May 3, 2001.

Costs, if any, shall be awarded by the Court of Appeal.

WITNESS MY HAND AND
OFFICIAL SEAL OF THE COURT,
06/06/2001

FREDERICK K. OHLRICH, Clerk

[SEAL]

By /s/ Deborah Benko
DEPUTY

[Attached Opinion Of The Supreme Court Of California Omitted In Printing.]

COURT OF APPEAL – STATE OF CALIFORNIA
FOURTH APPELLATE DISTRICT
DIVISION THREE

Carol S. Jimenez
5182 Katella Avenue
Suite 106
Los Alamitos, CA 90720

GEORGE McCALL et al.,
Plaintiffs and Appellants,

v.

PACIFICARE OF CALIFORNIA, INC.,
Defendant and Respondent.

G024030
788545

REMITTITUR

I, Stephen M. Kelly, Clerk/Administrator of the Court of Appeal of the State of California, for the Fourth Appellate District, Division III, do hereby certify that the decision entered in the above-entitled cause on December 6, 1999 has now become final.

[X] Appellant [ ] Respondent to recover costs
[ ] Each party to bear own costs
[ ] Costs are not awarded in this proceeding
[ ] See decision for costs determination

Witness my hand and the Seal of the Court affixed at my office this June 14, 2001.

Stephen M. Kelly
Clerk/Administrator

By: /s/ Diane R. Hernandez
Deputy Clerk

cc: All Counsel (copy of remittitur only, California Rules of court, Rule 25(e)).

SUPERIOR COURT OF CALIFORNIA
COUNTY OF ORANGE,
CENTRAL JUSTICE CENTER
MINUTE ORDER

Department: C24

COURT CONVENED AT: **ON:** 7-12-2001

JUDGE/COMM:
THIERRY P. COLAW

CLERK: C. FALKENBERG

REPORTER:

BAILIFF:
M. AGUILAR

AND THE FOLLOWING PROCEEDINGS WERE HAD:

788545 MCCALL VS PACIFICARE

NO APPEARANCES.

IN ACCORDANCE WITH SUPREME COURT RULING DIRECTING THE TRIAL COURT TO REVERSE THE RULING OF 7-17-2001 [SIC], THE COURT HEREBY RULES AS FOLLOWS: THE ORDER DISMISSING THE ACTION AND SUSTAINING THE DEMURRER OF PACIFIC CARE AND GREATER NEWPORT PHYSICIANS WITHOUT PREJUDICE IS VACATED. COURT RULES THAT THE DEMURRER IS OVERRULED WITH 30 DAYS LEAVE TO ANSWER. PLAINTIFF TO GIVE NOTICE. ENTERED 7-12-2001

HOUCK & BALISOK, RUSSELL BALISOK, 535 NORTH BRAND BLVD., STE 501, GLENDALE, CA 91203

CERTIFICATE OF SERVICE BY MAIL

I, ALAN SLATER, Executive Officer/Clerk of the Superior Court, in and for the County of Orange, State of California, hereby certify that I am not a party to the within action or proceeding and that on July 12, 2001, I served a copy of this document on the parties named herein by depositing true copies, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail box at Santa Ana, California addressed as indicated above.

Dated: July 12, 2001 by CHRISTINE FALKENBERG,
Deputy Clerk
Chris Falkenberg

Supreme Court, U.S.
FILED
AUG 31 2001
CLERK

(3)

No. 01-199

In the Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC. AND
GREATER NEWPORT PHYSICIANS, INC.

Petitioners,

v.

BARBARA MCCALL
Individually and as Trustee, etc.,

Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of California

BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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BRIEF OF THE AMERICAN ASSOCIATION OF HEALTH PLANS, THE AMERICAN BENEFITS COUNCIL, AND THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*[1]

The American Association of Health Plans, Inc. (AAHP) is the national association for the managed health care community. Its membership includes health maintenance organizations (HMOs), preferred provider organizations (PPOs), third-party health benefit administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1,000 managed health care organizations serving nearly 150 million Americans. AAHP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to member health plans. A significant number of AAHP member health plans participate in the Medicare program and, therefore, are directly affected by the issue presented by this case.

The American Benefits Council (the "Council") is a broad-based, non-profit trade association founded in 1967 to protect and foster the growth of this nation's privately sponsored employee benefit plans. The Council's members include both small and large employer-sponsors of employee benefit plans, including many Fortune 500 companies. Its

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[1] The parties have consented to the filing of this brief; the written consents have been filed with the Clerk. This brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the *amici curiae*, their members, and their counsel made a monetary contribution to the preparation and submission of this brief.

members also include many employee benefit plan support organizations, such as actuarial and consulting firms, insurers, banks, investment firms and other professional benefit organizations. Collectively, the Council's approximately 250 members sponsor and administer plans covering more than 100 million plan participants and beneficiaries.

The Health Insurance Association of America (HIAA) is one of the largest associations of health insurance companies in the world. HIAA is an advocate for the private, market-based health insurance system. Its more than 300 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection to more than 123 million Americans. HIAA develops and advocates federal and state policies that build upon our health care system's quality, affordability, accessibility and responsiveness.

INTRODUCTION AND SUMMARY OF ARGUMENT

Despite the long-settled rule that Medicare beneficiaries may not raise claims "arising under" the Medicare Act without first exhausting their administrative remedies (see 42 U.S.C. §§ 405(g),(h)), the California Supreme Court has allowed a Medicare beneficiary enrolled in an HMO to bypass administrative review procedures and file state-law tort claims predicated on the HMO's denial of benefits. The court's decision – which directly affects the large population of Medicare beneficiaries residing in California – will undermine Medicare's carefully structured administrative review process and impose unwarranted costs on the Medicare system. Moreover, by threatening participating health plans with expansive and unpredictable tort liability for their coverage decisions, the decision below will inhibit the development of alternatives to the traditional fee-for-service Medicare program.

In recent years, Congress has made efforts to expand participation by Medicare beneficiaries in a variety of health care plans, including HMOs, offered by private entities under contract with the federal government. These plans provide Medicare beneficiaries with more options for their health care coverage – and, in many cases, additional benefits – while saving the government money. At the same time, Congress and the Secretary of Health and Human Services have strengthened the already extensive internal and external appeal rights of Medicare beneficiaries participating in Medicare HMOs and other non-traditional health plans. The government has recognized that the prompt resolution of disputes over benefits is particularly important in the managed care arena, where benefit decisions are sometimes made *before* treatment is provided. The administrative review procedures now in place are designed to promote uniform and speedy resolution of claims for benefits and minimize costs while ensuring that beneficiaries suffer no harm from the improper denial of medical services.

The decision below will allow Medicare beneficiaries to ignore the administrative review process and, instead, to seek damages from the health plans that denied their requests for services. This will harm the beneficiaries themselves, who by failing to appeal administratively will give up their best chance of obtaining the services they desire. It will harm private health plans participating in Medicare, by subjecting them to exploding litigation costs and inconsistent standards of conduct. And it will harm the Medicare program, by increasing costs and discouraging private organizations from offering Medicare beneficiaries the variety of health care options that Congress wished to provide to them. Because the potential effects of the California Supreme Court's decision are so significant, review by this Court plainly is warranted.

ARGUMENT

A. Alternatives To Traditional Fee-for-Service Coverage Are An Increasingly Important Part Of Medicare.

Under Medicare's traditional fee-for-service program, the federal government makes a payment for each individual Medicare-covered service provided to a beneficiary. In 1982, Medicare's risk-contract program was created, allowing private entities, mostly HMOs, to contract with the Health Care Financing Administration (HCFA) to provide services to Medicare enrollees.[2] See 42 U.S.C. § 1395mm. Under this program, the government pays the HMO a preset monthly payment for each enrollee. See *id.* § 1395mm(a)(5)(A)-(B).[3] In exchange, the HMO agrees to provide each enrollee with coverage of all Medicare-covered items and services, as well as additional benefits under specified circumstances. See *id.* § 1395mm(b)(2).

Medicare managed care programs offer advantages to both beneficiaries and the government. Most plans provide benefits not covered by the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. Statement of Bruce C. Vladeck, Ph.D., Administrator, HCFA, before the Subcommittee on Health of the House Committee on Ways and Means (March 6, 1997) <http://www.house.gov/wys_means/-health/105cong/3-6-97/3-6-vlad.htm.> Many Medicare HMOs also offer preventive care services, such as routine screening for chronic illnesses, functional assessments, and education for self-care. See P. Fox & T. Fama, *Managed*

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[2] In June 2001, HCFA changed its name to the "Center for Medicare and Medicaid Services," but this amicus brief, like the petition, refers to this entity as HCFA.

[3] Some HMOs are reimbursed based on actual usage of health services by their members. See 42 U.S.C. § 1395mm(h).

Care and the Elderly: Performance and Potential, 20 GENERATIONS 31, 33 (1996). Beneficiaries in Medicare managed care programs also generally incur fewer out-of-pocket expenses than they would pay under the fee-for-service program. See J. Baker, *Medicare HMOs and the Medicare+Choice Program*, 27 PLI/NY 109, 114 (1998). At the same time, the government saves money when beneficiaries enroll in managed care because the fixed fee it pays for each enrollee is lower, on average, than the amount it would spend to cover services provided under the traditional fee-for-service arrangement. *Id.* at 117. Even with those cost savings, "[m]ost studies have found that the quality of care received by Medicare beneficiaries in HMOs is comparable to or better than that received in [fee-for-service] settings." J. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL'Y & L. 595, 610 (1997).

In the last decade, managed care has became a far more significant part of the Medicare landscape. In 1990, only about 3% of Medicare beneficiaries were enrolled in a managed care program. Congressional Research Service, MEDICARE+CHOICE (updated Jan. 10, 2001) ("CRS Report") at 8. By 2000, about 16% of beneficiaries had enrolled in a managed care plan. *Id.* at 4. Nearly one-quarter of all Medicare beneficiaries enrolled in managed care reside in California. *Id.* at 15.

On August 5, 1997, as part of the Balanced Budget Act of 1997 (Pub. L. No. 105-33 § 1851, 111 Stat. 251), Congress created the Medicare+Choice (M+C) Program in an effort to provide additional opportunities for beneficiaries to move from traditional fee-for-service coverage to alternative health plans. The M+C Program not only allows beneficiaries to participate in traditional managed care plans such as HMOs, but also aims to give them access to a broad array of plans

comparable to those available through private insurance.[4] These include Provider Sponsored Organizations (which are a type of HMO established by a provider such as a hospital), Preferred Provider Organizations (which are groups of providers that contract with a health plan or an insurer to offer their services on a fee-for-service basis), Medical Savings Accounts (under which beneficiaries purchase a private high deductible catastrophic health insurance policy and establish a tax-free savings account for paying out-of-pocket expenses), and Private Fee-for-Service Plans (under which beneficiaries purchase health insurance policies for which HCFA will contribute a flat-fee payment). See generally J. Baker & S. Levin, *Medicare: Nuts and Bolts*, 75 PLI/NY 225, 238-239 (2000). The Congressional Budget Office predicts that, by 2010, about 31% of all Medicare beneficiaries – or about 14 million enrollees – will participate in M+C plans. CRS Report at 8. However, beneficiaries' access to M+C plans will depend upon the willingness of private health plans to offer services under the program.[5]

B. Congress Has Granted Medicare Beneficiaries Expansive Rights To Appeal The Denial Of Treatment By Organizations Providing Medicare Coverage.

A beneficiary's right to appeal a denial of benefits has long been a key feature of Medicare's risk-contract program

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[4] The 1997 amendments to the Medicare Act provided that HCFA may not enter into or renew a contract with a risk-based HMO under the former statutory authority after the rules for M+C contractors come into effect. See 42 U.S.C. § 1395mm(k). Thus, all Medicare HMOs that have remained in the program have become M+C organizations.

[5] In September 2000, about 72% of the 39 million Medicare beneficiaries had access to one or more of the 260 participating M+C plans. CRS Report at 4.

and continues to be central under the Medicare+Choice program. In the traditional fee-for-service program, most appeals are filed by physicians and suppliers, rather than beneficiaries, and concern the denial of payment *after* care has been rendered. See Testimony of Michael Hash, Deputy Administrator, HCFA, before the Subcommittee on Health of the House Committee on Ways and Means (April 22, 1999) ("Hash Testimony") <http://www.hcfa.gov/testmony/1999/-medcov1.htm.> In contrast, when beneficiaries are enrolled in Medicare HMOs, denials generally *precede* the delivery of care, and appeals are brought by beneficiaries who are seeking medical services. *Id.* at 3-4. See Testimony of Carol Cronin, Director, Center for Beneficiary Services, HCFA, before the Senate Special Committee on Aging (April 13, 1999) ("Cronin Testimony") <http://www.hcfa.gov/testmony/-1999/appeal1.htm>. Moreover, while coverage determinations in the fee-for-service arena are made initially by the government or its fiscal intermediary (see *Heckler* v. *Ringer*, 466 U.S. 602, 606 (1984)), coverage determinations in Medicare's managed care program are made in the first instance by the participating health plan.

The government has recognized that the appeals process plays a crucial role in assuring beneficiaries "that managed care incentives to reduce unnecessary care will not be allowed to limit appropriate care." Cronin Testimony, at 5. See K. Pippin, *Increasing Consumer Power in the Grievance and Appeal Process for Medicare HMO Enrollees*, 33 U. MICH. J. L. REF. 133, 134 (1999 and 2000). Beneficiaries in the M+C program thus have been provided with extensive rights to appeal adverse decisions regarding their requests for service, and these rights have been enhanced repeatedly over the last several years. See generally J. Gladieux, *Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J. L. & MED. 61, 75-81, 86-90 (1999) (describing recent changes to administrative appeal process).

Indeed, although the Medicare managed care appeal process has been criticized, beneficiaries are afforded more extensive appeal rights than have been available in the private sector. In 1998, a member of the AARP Board of Directors testifying before Congress gave the Medicare managed care appeal process "high marks," stating: "Compared to what is available in private sector managed care, the Medicare appeal process remains the gold standard, despite its shortcomings." Statement of Jim Parkel, Member AARP Board of Directors, before the Subcommittee on Health of the House Committee on Ways and Means (April 23, 1998) <http://www.aarp.org/wwstand/testimony/1998/testparkel.html>.

A review of the rules bears this out. Under current regulations,[6] each M+C organization must have a procedure for making timely decisions on a request for benefits. 42 C.F.R. § 422.566(a). The organization must notify the enrollee of its decision within 14 days after a request is made. *Id.* § 422.568(a). If the organization decides to deny service in whole or in part, it must provide the enrollee with written notice of the denial, which must set forth the process for appealing the adverse determination. *Id.* § 422.570(d). An enrollee has 60 days within which to request reconsideration of an adverse determination. *Id.* §§ 422.578, 422.582(b). The organization must respond to a request for reconsideration within 30 days, or sooner if the beneficiary's condition requires it. *Id.* § 422.590.

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[6] The appeal procedures for M+C organizations, which implement Section 1852(g) of the Medicare Act (42 U.S.C. § 1395w-22) and became effective on June 27, 1998, appear at 42 C.F.R Part 422, Subpart M. These regulations have superseded the regulations applicable to risk-based Medicare HMOs that contracted with HCFA before the creation of the M&C Program, which remain codified at 42 C.F.R Part 417. See 63 Fed. Reg. 34968, 34969 (June 26, 1998).

M+C organizations also must provide expedited review procedures for situations in which delay "could seriously jeopardize the enrollee's life, health, or ability to regain maximum function." *Id.* § 422.566(a). In such cases, the organization must make its initial determination within 72 hours, and must respond to a request for reconsideration of an adverse determination within 72 hours. *Id.* §§ 422.572(a), 422.590(d)(1). That time frame is abbreviated if the patient's condition demands it. *Ibid.*

When an M+C organization affirms its adverse determination in whole or in part, it must forward the case to an independent, outside review entity for a final reconsidered determination. *Id.* § 422.592(a). HCFA contracts with the Center for Health Dispute Resolution (CHDR) to perform this function. CHDR must act on expedited appeals within 72 hours and must act on all other appeals within 14 days. *Id.* § 422.592(b); Hash Testimony, at 4.

If the amount in controversy is $100 or more, a beneficiary (but not the M+C organization) may appeal the independent review contractor's decision to a Social Security Administration Administrative Law Judge (ALJ). 42 C.F.R. §§ 422.600(a), 422.602(a). Any party dissatisfied with the ALJ's decision may appeal to the Health and Human Services Departmental Appeals Board. *Id.* § 422.608. In cases involving at least $1,000, either party may seek judicial review of the decision in federal district court, as provided in 42 U.S.C. § 405(g). See *id.* § 1395w-22(g); 42 C.F.R. § 422.612. The rights of M+C enrollees to appeal an adverse decision to federal district court are identical in substance to the rights afforded to beneficiaries enrolled in HMOs with which HCFA contracted under prior law. Compare 42 U.S.C. § 1395w-22(g) with *id.* § 1395mm(c)(5)(B) (both of which grant "judicial review of the Secretary's decision as provided in Section 205(g)" of the Medicare Act, 42 U.S.C. § 405(g)).

Beneficiaries who invoke the administrative appeal process often obtain the medical services they seek. In a July 1998 survey conducted by the General Accounting Office (GAO), Medicare HMOs reported that, between January 1996 and May 1998, they reversed their initial denials in approximately 75% of cases presented to them for reconsideration. GAO, MEDICARE MANAGED CARE: GREATER OVERSIGHT NEEDED TO PROTECT BENEFICIARY RIGHTS (April 1999) ("GAO Report") at 2. Denials that were not overturned were forwarded to CHDR for further review. *Id.* at 12. In 1999, CHDR decided 17% of the cases that it reviewed in favor of the beneficiary and affirmed the HMO's decision in 67% of cases; another 12% of cases were withdrawn, 2% were partially reversed and, in 1% of cases, beneficiaries were permitted retroactively to disenroll from the managed care program and switch to fee for service. CHDR, Medicare Managed Care Reconsideration Data (2/1/2001) ("CHDR Data"), at Table 1.

As participation in Medicare managed care plans has expanded, the number of cases reviewed also has increased. In 1997, 9,024 appeals were sent to CHDR. Statement of Michael Hash, Deputy Administrator, HCFA, before Subcommittee on Health of the House Committee on Ways and Means (April 23, 1998) ("Hash Statement") <http://www.-hcfa.gov/testmony/1998/98_0423.htm. That number increased to 14,745 cases in 1998, and 20,403 cases in 1999. See Cronin Testimony, at 5; CHDR Data, at Table 1.[7]

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[7] The appeal process is likely to become even more important in the future, as new limits on Medicare beneficiaries' ability to disenroll from managed care plans become effective. Currently, a Medicare beneficiary enrolled in a managed care plan may disenroll at the end of any month and elect traditional fee-for-service coverage. 42 C.F.R. § 406.21(f); see also *id.* §§ 407.12-.15. Beginning on January 2, 2002, however, Medicare beneficiaries will be able to change their health plan only during an annual "open

C. The Decision Below, Which Permits Beneficiaries To Sidestep The Administrative Process For Appealing The Denial Of Medical Services In Favor Of Bringing A Tort Action, Is A Significant Threat To The Medicare+Choice Program.

Based on its mistaken conclusion that this lawsuit was not "inextricably intertwined with a claim for Medicare benefits" (Pet. App. 16a), the California Supreme Court allowed a Medicare enrollee who had not appealed his HMO's alleged denial of service to pursue state tort claims seeking damages allegedly resulting from the denial. Under that ruling – which now governs the 24% of Medicare+Choice enrollees who reside in California and will create uncertainty as to the rights of enrollees in other jurisdictions – a Medicare beneficiary may simply sidestep the process that Congress and the Secretary of Health and Human Services created to resolve coverage disputes between Medicare HMOs and beneficiaries quickly, fairly and cost-effectively. "If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state * * * causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, 903 F.2d 480, 487 (7th Cir. 1990). Such substantial interference with a federal program should not be permitted at all; at the very least, any decision to expand collateral state-court litigation over core determinations made within one of the largest federal programs merits this Court's immediate consideration.

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season." See *id.* § 422.62(a)(4). Because beneficiaries who are aggrieved by a coverage decision by a M+C organization no longer will be able to withdraw from the plan and go the fee-for-service route, the number of appeals from denials of benefits can be expected to increase.

1. Allowing beneficiaries who have not invoked the administrative process to seek damages predicated on the refusal of benefits will be of little help to beneficiaries, but will impose substantial and unwarranted new costs on the Medicare system.

As discussed above, participants in Medicare managed care plans have extensive rights to appeal the denial of coverage for medical services. Seeking administrative review of a denial of benefits is a quick and effective way for a beneficiary to obtain medical treatment that he or she feels has been wrongfully withheld. As noted, Medicare HMOs themselves grant nearly 75% of requests for reconsideration that are presented to them, and those denials that are reaffirmed are automatically reviewed by an independent outside organization. The availability of expedited review ensures that a beneficiary will not risk his health by invoking his administrative remedies. Use of the administrative process reduces the chances that a beneficiary will suffer any consequential harm from an *erroneous* failure to provide benefits and minimizes the cost of determining that benefits have been *correctly* withheld.

Permitting beneficiaries who have ignored their appeal rights to sue for damages will do nothing to preserve the health of patients, but will impose enormous litigation costs on the private entities that choose to enroll Medicare beneficiaries in their health plans. Medicare HMOs make thousands and thousands of coverage decisions each year, and they must deny requests for treatment that are not covered by Medicare or otherwise covered by the plan. If even a tiny fraction of the claims denied result in tort litigation, then the cost to a private entity of participating in the Medicare program will skyrocket. These costs can be avoided, without harm to patients, if all claims are channeled to the administrative appeal process.

This case exemplifies the point. As the transcript of his deposition makes clear,[8] respondent McCall never even gave his HMO the chance to consider providing him with the benefits he claimed he needed. According to McCall, his treating physician advised him that PacifiCare would require him to undergo a lung transplant at UCLA or Cedars-Sinai, but would not cover a lung transplant at the University of California at San Diego, where McCall wished to have the procedure. Petitioner's Lodging, at 13-14. When given this news, McCall immediately disenrolled from PacifiCare and enrolled in the traditional fee-for-service program, which did not restrict his choice of hospitals. *Id.* at 14-15, 21. Contending that PacifiCare had "chose[n its] well-being over [his]" (*id.* at 12), McCall sought to recover as damages the additional out-of-pocket costs he incurred after he disenrolled from PacifiCare to obtain medical services that would have been covered by his HMO but were not covered by the fee-for-service program. *Id.* at 24.

Both McCall and PacifiCare would have been far better off had McCall taken advantage of the administrative process to appeal the denial of benefits. If it was indeed improper for PacifiCare to direct McCall to UCLA or Cedars-Sinai rather than UCSD for his lung transplant, then a request for reconsideration to PacifiCare itself and, if necessary, to an independent review body, might well have been fruitful. If it had been, McCall would have received the treatment he desired and would not have suffered the inconvenience and expense of returning to the fee-for-service program. If, instead, PacifiCare was justified in requiring McCall to seek treat-

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[8] Although the courts below did not consider them, the facts disclosed in Mr. McCall's deposition are relevant here because they demonstrate the importance of channeling disputes concerning the provision of medical services to the administrative appeal process. Petitioners have lodged a copy of the relevant deposition transcript with the Clerk of the Court.

ment within its network, then McCall would promptly have received a ruling to that effect and avoided protracted litigation. Instead, years have passed since McCall filed his complaint (and McCall himself has died), yet the California courts are still a long way from deciding whether PacifiCare's denial of benefits was appropriate.

The costs imposed by allowing other Medicare beneficiaries to take their grievances to the courts under these circumstances will dramatically affect the future prospects of the Medicare+Choice program. As noted above, the program's success depends on the willingness of a variety of health plans to enter into contracts with HCFA to serve Medicare beneficiaries. In light of the program's administrative burdens and slim profit margins, securing the participation of health plans has at times been difficult. See J. Gladieux, *supra*, 25 AM. J. L. & MED. at 102; CRS Report, at 4. Allowing more Medicare beneficiaries to sue their HMOs – or merely creating uncertainty about whether or not they will be able to do so – may tip the balance against participation for many organizations. This will reduce the health care options available to senior citizens and individuals with disabilities.

2. The California Supreme Court's decision also will reduce consistency in benefit determinations. Requiring aggrieved beneficiaries to employ the administrative process fosters uniform treatment of claims that benefits have been wrongly denied. As noted above, HCFA now contracts with a single independent contractor to review *all* instances in which an HMO or other M+C organization denies reconsideration of a claim for benefits. Similarly, the ALJs who provide further review of denials of treatment – like the members of the Appeals Board that reviews ALJ decisions – review scores of Medicare treatment decisions. Although there is no guarantee that similar cases will fare identically in the administrative process, the system is designed to maximize the chances that cases will be resolved consistently. See

Shalala v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) ("'channelling' * * * virtually all legal attacks through the agency * * * assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts"). Such consistency is fair to beneficiaries and provides M+C organizations with clear guidance for deciding future requests for benefits.

In contrast, the approach sanctioned by the California Supreme Court is a recipe for havoc. As the dissenting justices below observed, "plaintiffs' ability to prevail on their state law causes of action inevitably turns upon a determination that plaintiff George McCall was entitled to a Medicare benefit * * * and that PacifiCare had no right to deny such benefit because it was reasonable and necessary for treatment of his condition." Pet. App. 31a. Allowing state courts to rule on the propriety of benefit determinations in the course of adjudicating a Medicare HMO's tort liability will result in inconsistent decision-making. Because they lack standards for evaluating benefit determinations, judges and juries inevitably will resolve similar cases differently from one another and from the experts deciding the same issues within the administrative framework. If states other than California begin to entertain tort suits based on the coverage decisions of Medicare HMOs, the divergence among cases will increase, and beneficiaries will be encouraged to engage in forum-shopping.

This inconsistency will be unfair to beneficiaries, as it may encourage HMOs to vary their benefit determinations according to where the beneficiary resides. Allowing the state tort system to operate alongside the administrative process also will make it more difficult for Medicare HMOs to discern what rules they should follow in particular cases.

Indeed, if benefits decisions are exposed to the vagaries of the tort system, M+C organizations may decide to grant

even the most marginal requests for service, thereby increasing the costs of coverage and defeating the salutary purposes of managed care. Alternatively, they may simply withdraw from the Medicare program. Cf. *Midland Psychiatric Assocs., Inc.* v. *United States*, 145 F.3d 1000, 1005 (8th Cir. 1998) ("insurers * * * might well rethink their contracts with the Government if they had to make Medicare claims decisions under the threat of tort liability"). This would defeat the goals of the Medicare+Choice program, by depriving beneficiaries of the option of participating in health care plans that may suit their needs better than traditional fee-for-service coverage.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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IN THE

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PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC., AND
GREATER NEWPORT PHYSICIANS, INC.,
Petitioners,

v.

BARBARA MCCALL,
Individually and as Trustee, etc.,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of California

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REPLY BRIEF

The opposition brief rests on two, erroneous premises:

First, Respondents wrongly assert that the California court did not decide the question presented in the petition – *viz.*, whether state law claims predicated on a wrongful denial of Medicare benefits "aris[e] under" the Medicare Act, 42 U.S.C. § 405(h). Second, Respondents contend that even if the court so held, the holding will not significantly affect the Medicare program. On these sands, Respondents build their case that the petition should be denied.

In fact, the California Supreme Court expressly opined that it was deciding "the issue whether state law claims against a [Medicare contractor], arising out of its refusal to provide services under a Medicare-subsidized health plan, fall within the exclusive review provisions of the Medicare Act requiring exhaustion of administrative remedies." App. 1a. The complaint alleges that George McCall was denied a Medicare benefit and that this denial breached a number of state law and federal duties.[1] Respondents' newly-minted contentions that "[n]either Pacificare nor GNP denied George coverage of a particular service" and that the complaint alleges "bad care and treatment decisions," Opp. 2, 13, are unsupported by any citation to the complaint. The complaint presents, and the lower courts decided, the issue presented by the petition.

The California court's decision has all the injurious consequences set forth in the petition. It finally decides a

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[1] App. 2a ("[a]llegedly, Dr. Shukla, PacifiCare and GNP repeatedly refused to refer Mr. McCall to a specialist for a lung transplant or provide other needed care, and ultimately forced him to disenroll from PacifiCare in order to get on the Medicare list for a transplant"); *id.* at 41a ("[t]he gravamen of [the] complaint is that, to save money, [petitioners] repeatedly refused to refer him to a specialist for a lung transplant, or provide other needed care, and ultimately forced him to leave the plan").

federal question in a way that seriously erodes an important federal policy for purposes of 28 U.S.C. § 1257. See *Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 482-85 (1975). It cannot be reconciled with this Court's authority; further, as the court below acknowledged, "disagreement exists among [the lower] state and federal courts" on the question presented here. App. 1a. Equally to the point, unless this Court steps in, the decision will profoundly damage the Medicare program. The channeling requirement in the Medicare Act serves important federal goals by promoting uniformity and prompt determination of claims and limiting consequential damages. We turn to a detailed demonstration of these points.

I. THIS COURT PLAINLY HAS JURISDICTION.

Respondents assert that this Court lacks jurisdiction because the California court's decision is not final under 28 U.S.C. § 1257, as interpreted in *Cox Broadcasting Corp.* v. *Cohn*, 420 U.S. 469 (1975). Respondents are plainly wrong.

The petition falls squarely within *Cohn*'s delineation of state court judgments that are final under section 1257 even though further state court proceedings are pending:

> [T]here are those situations where the federal issue has been finally decided in the state courts with further proceedings pending in which the party seeking review here might prevail on the merits on nonfederal grounds, thus rendering unnecessary review of the federal issue by this Court, and where reversal of the state court on the federal issue would be preclusive of any further litigation on the relevant cause of action rather than merely controlling the nature and character of, or determining the admissibility of evidence in, the state proceedings still to come. [420 U.S. at 482-83.]

These criteria of finality are clearly met. If petitioners are successful in the pending state lawsuit, the federal jurisdictional defense becomes moot. And, this Court's reversal of the decision would require dismissal of the

complaint for lack of state court jurisdiction. Instead, Respondents argue that the decision does not satisfy *Cohn*'s further requirement that "a refusal immediately to review the state-court decision might seriously erode federal policy," 420 U.S. at 483. This decision, however, determines the scope of the channeling requirement, a central component of the Medicare program. Whatever this Court ultimately decides, the California decision may seriously erode federal policy.

In analogous cases, this Court routinely deems state court decisions final. In *Belknap, Inc.* v. *Hale*, 463 U.S. 491 (1983), the Court deemed final a state court judgment rejecting a defense of federal pre-emption, because permitting "the proceedings to go forward in the state court without resolving the pre-emption issue would involve a serious risk of eroding the federal statutory policy of requiring the subject matter of respondents' cause to be heard by the . . . Board, not by the state courts." *Id.* at 497 n.5 (internal quotations omitted; omission in original). Cf. *Constr. Laborers* v. *Curry*, 371 U.S. 542, 550 (1963) (where the proper forum for trying the issue in the state court turns on the resolution of the federal question, the question should be decided by the Supreme Court sooner rather than later); *Southland Corp.* v. *Keating*, 465 U.S. 1, 6-8 (1984) (a state court judgment is final when a party must face further proceedings in the state courts that those courts lack the power to conduct).

The decision of the California Supreme Court is final.

II. THE COURTS ARE IN CONFLICT.

Ignoring the California court's recognition that a conflict exists, Respondents argue that "[w]ithout exception," all courts "f[ind] that state law claims, including those seeking tort remedies based upon failure to provide Medicare covered services, may be asserted against an HMO or other health care provider as they do not arise under the Medicare Act." Opp. 9. This argument is over-inclusive and under-inclusive,

because it relies on cases that do not so hold and excludes cases directly on point.

a. Respondents correctly characterize cases such as *Ardary* v. *Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996), *Plocica* v. *Nylcare of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999), and *Warternberg* v. *Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998), as holding that state court lawsuits based upon a failure to provide Medicare benefits do not arise under the Medicare Act. But they cite two court of appeals decisions that do not remotely stand for that proposition.

In *Talbot* v. *Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997) and *Alcare, Inc.-N.* v. *Baggiano*, 785 F.2d 963 (11th Cir. 1986), the issue presented was "whether a plaintiff who alleges a violation of the nursing care facility resident rights provisions of the Medicare [or Medicaid] Act must exhaust her *state administrative remedies* before bringing a cause of action for those violations pursuant to 42 U.S.C. § 1983." 118 F.3d at 216 (emphasis provided; citations omitted). The *Talbot* court expressly distinguished its decision from *Heckler* v. *Ringer*, 466 U.S. 602 (1984), because it involved "the exhaustion of *state* administrative remedies" and the plaintiff was not claiming a denial of Medicare benefits. 118 F.3d at 219 n.1. Nothing in either decision purports to address the breadth of section 405(h).[2]

b. Respondents' conflict analysis is under-inclusive because she excludes *Bodimetric Health Services, Inc.* v. *Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990), *Midland Psychiatric Associates, Inc.* v. *United States*, 145 F.3d 1000 (8th Cir. 1998), and *Affiliated Professional Home Health Care Agency* v. *Shalala*, 164 F.3d 282 (5th Cir. 1999). These

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[2] Respondents take us to task for an alleged "fail[ure] to apprise this Court of the numerous federal cases directly on point with the present case." Opp. 11 (citation omitted). But the petition cites *Ardary*, *Plocica* and *Wartenberg*, and neither *Talbot* nor *Alcare* is on point.

cases, however, all address the meaning of the phrase "arising under" and conclude that where state law claims are "inextricably intertwined" with Medicare benefits claims, the administrative-exhaustion and federal-judicial review requirements apply. Pet. 14-17 (internal quotation marks omitted) (quoting *Bodimetric*, 903 F.2d at 483). Under these holdings, this case would have been dismissed for lack of jurisdiction.

Respondents distinguish these cases because they were brought not by Medicare beneficiaries, but by Medicare providers. Opp. 11. Respondents nowhere explain why this distinction makes any difference. The statutory language does not distinguish among plaintiffs; it simply requires channeling of "any claim arising under" the benefits provisions of the Medicare Act. 42 U.S.C. § 405(h). The meaning of this provision does not vary with the identity of the plaintiff bringing the state court action.

The holding that "[a] party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits" and "by recharacterizing [its] claims under state and federal causes of action," *Bodimetric*, 903 F.2d at 487, conflicts directly with the decision in this case. In addition, petitioners showed that the California decision conflicts with this Court's established interpretations of section 405(g) and (h). Pet. at 19-23. Respondents ignore this alternative basis for review. Reivew is plainly warranted to resolve these conflicts.

III. THE DECISION BELOW IS WRONG.

Respondents ignore the statutory text; this Court's mandate that the phrase "arising under" be interpreted "quite broadly," *Ringer*, 466 U.S. at 615; this Court's interpretations of "arising under" in other contexts, Pet. 24 n.10; and Congress' intent that "the remedies provided by [the Act's] review procedures shall be exclusive," *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 n.11 (1982) (emphasis omitted). Without repeating

the affirmative case made in the petition, we respond to the opposition's arguments that the decision below was correct.

1. Respondents assert that the Medicare Act, as interpreted by HCFA, "plainly states that tort and other state law claims against an HMO are not preempted, even if such claims also involve Medicare coverage determinations." Opp. 12 (citing App. 14a-15a).[3] The Medicare Act contains no such broad anti-preemption provision. In fact, it *pre-empts* all state laws and regulations "relating to" or "pertaining to" specified areas, including "coverage determinations." 42 U.S.C. § 1395w-26(b)(3); 42 CFR § 422.402. This pre-emption provision is entirely consistent with the broad scope of the channeling provisions.

Without addressing the language of the pre-emption provision, Respondents seek *Chevron*[4] deference for the preamble to HCFA's regulations implementing the BBA. It states that a Medicare contractor's "denial of care that a beneficiary believes to be covered care is subject to the Medicare appeals process," but may also be the "subject of a tort case under State law *if medical malpractice is alleged*, or of a state contract law claim *if an enrollee alleges that the [contractor] has obligated itself to provide a particular service under State law without regard to whether it is covered under its [Medicare] contract.*" 63 Fed. Reg. 34,967, 35,013 (June 26, 1998) (emphasis supplied).[5]

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[3] In so arguing, Respondents rely on the express pre-emption provision that the BBA added to the Medicare Act, 42 U.S.C. § 1395w-26(b)(3). The Medicare Act had virtually the same pre-emptive effect prior to the BBA's enactment "'based on general constitutional Federal preemption principles.'" App. 38a (citing 63 Fed. Reg. 34,967, 35,012 (1998)).

[4] *Chevron U.S.A. Inc.* v. *Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984).

[5] It is doubtful that a *preamble* to a rule would receive *Chevron* deference. *See United States* v. *Mead Corp.*, 121 S. Ct. 2164, 2171 (2001).

These statements are easily harmonized with the Medicare Act's channeling requirement. Medical malpractice and state contract claims that are inextricably intertwined with Medicare benefits determinations must be channeled, while other such claims may be pursued in state court. As the dissent below stated, HCFA "explains that preemption does not extend to all medical malpractice and contract claims, [but] that has always been the case where the claims were not inextricably intertwined with a benefits determination. . . . [T]he claims asserted here do not fall within these long acknowledged categories of exempted claims." App. 39a.

Petitioners agree that the Medicare Act does not require exhaustion of or pre-empt *all* state law claims of medical malpractice or breach of contract simply because a Medicare beneficiary is involved. Plaintiff has not, however, alleged malpractice or breach of contract. Opp. 13. Where, as here, the Medicare beneficiary seeks merely to challenge a Medicare contractor's determination of benefit eligibility, that determination must be challenged through the Medicare Act's administrative processes.[6] Mr. McCall was required to use that process to challenge the eligibility decision here.

2. Respondents next argue that the decision below is correct because it involves an HMO (which receives a fixed monthly amount to administer and provide Medicare benefits) instead of fiscal intermediaries (which receive administrative fees from the government for determining after-the-fact whether a Medicare claim should be paid, but do not provide benefits). Opp. 13-14. Respondents nowhere explain how this difference alters the meaning of section 405(h). For

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[6] As the *amicus* brief of the American Association of Health Plans, the American Benefits Council, and the Health Insurance Association of America ("AAHP Br.") demonstrates, the administrative process is extremely effective when invoked, protecting the interests of beneficiaries and avoiding the costs and delays of litigation. AAHP Br. 10-11.

exhaustion purposes, the Medicare Act does not distinguish between fee-for-service and managed-care Medicare.

Respondents' unstated argument is that HMOs cannot be trusted to provide Medicare benefits because they have a profit motive to deny benefits, while fiscal intermediaries do not. These propositions are questionable; the Government will not contract with either HMOs that routinely deny appropriate benefits or fiscal intermediaries that routinely grant claims that should not be paid. The critical point, however, is that the policy judgment whether HMOs should be permitted to provide Medicare benefits and on what basis, is for Congress; and Congress has determined that claims "arising under" the Medicare Act's benefits provisions should be channeled, including claims against HMOs.

3. Finally, Respondents contend that some of their claims are "'grievances,'" not "'organization determinations,'" and that only the latter are subject to administrative review. Opp. 14. That distinction is not material here. The legal claims based on grievances – the alleged marketing fraud, failure to implement a quality assurance program, and involuntary disenrollment – are themselves based on the allegation Mr. McCall was unlawfully denied a Medicare benefit. As the dissent explained, all of plaintiffs' claims "are predicated on the central theory that PacifiCare, as a Medicare HMO, was required to comply with all Medicare rules and regulations, that reasonable and necessary health services covered by Medicare would not be denied, and that all available Medicare treatment options would be discussed and provided." App. 33a; see also *id.* ("[a]s for the disenrollment claim, plaintiff George McCall allegedly had to disenroll in order to get the lung transplant he sought"). Accordingly, all of the claims arise under the benefits provisions of the Act and must be administratively exhausted.

IV. THE DAMAGE THAT WILL BE CAUSED BY THE DECISION CANNOT BE OVERSTATED.

Respondents save the most specious part of their argument for last when they argue that the decision – which the dissent characterized as "all but assur[ing] that Medicare's administrative review process will cease to function as a meaningful limit on judicial review," App. 39a – will have only a limited impact on Medicare.

First, Respondents claim the decision's effect is limited to California HMOs, a claim which directly contradicts their contention that the decision follows uniform case law. While Respondents were wrong, the California decision does follow *Ardary*, *Plocica*, and *Wartenberg*. Moreover, almost one-quarter of all Medicare beneficiaries enrolled in managed care reside in California. AAHP Br. 5. Thus, the decision affects millions of Medicare beneficiaries. In any event, the differential treatment of Medicare beneficiaries resulting from the conflict on this issue is fundamentally unfair to all beneficiaries and damaging to the program.

Second, Respondents baldly contend that the ruling affects only HMOs. As explained *supra*, nothing in the decision limits its holding to HMOs. It allows a state court claim predicated on a wrongful denial of benefits to be styled as a tort claim seeking consequential damages and avoid the Medicare Act's channeling requirements. It is immaterial whether the defendant is a fiscal intermediary or an HMO.

Third, Respondents suggest, again without explanation, that the decision "is based upon the law prior to the [BBA]" and therefore that "the impact of this case may be limited in time." Opp. 15. The BBA did not, however, amend section 405(g) and (h) and did not alter the channeling requirement. Indeed, as Respondents themselves essentially concede, the BBA did not even significantly alter the Act's pre-emptive effect. See *supra* at 6 n.3. Respondents point to no provision of the BBA that limits the decision to the pre-BBA period.

Finally, Respondents contend that the decision will have no significant impact on the federal funding of Medicare. They observe correctly that the Government pays HMOs a fixed monthly amount to administer and provide Medicare benefits "regardless of the frequency, extent or kind of health services actually provided" to a Medicare beneficiary and conclude that the federal fisc will be unaffected by elimination of the channeling requirement. Opp. 16.

This contention is premised on the earlier, meritless argument that the decision affects only HMOs (in fact, fiscal intermediaries, too, will be subject to litigation and consequential damages). But, assuming Respondents' mistaken premise to be true, their position – that HMOs will continue to provide health services to Medicare beneficiaries for the same monthly payment even if beneficiaries can avoid the administrative-exhaustion and exclusive federal judicial-review provisions of the Medicare Act by styling their attacks as state law tort claims for consequential damages – is utterly frivolous. HMOs will either refuse to enroll Medicare beneficiaries, increasing the Government's costs, AAHP Br. 4-5, or will raise prices to account for the costs of litigating challenges based on benefits determinations and paying or insuring against consequential damages in such suits. *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 511-12 (1988) ("[t]he financial burden of judgments against [government] contractors would ultimately be passed through, substantially if not totally, to the United States itself, since . . . contractors will predictably raise their prices to cover, or to insure against" liability).

The California court's roadmap for easy circumvention of Congress' scheme conflicts with decisions of this and other courts and damages an important federal program.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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